# TEXAS REGISTER

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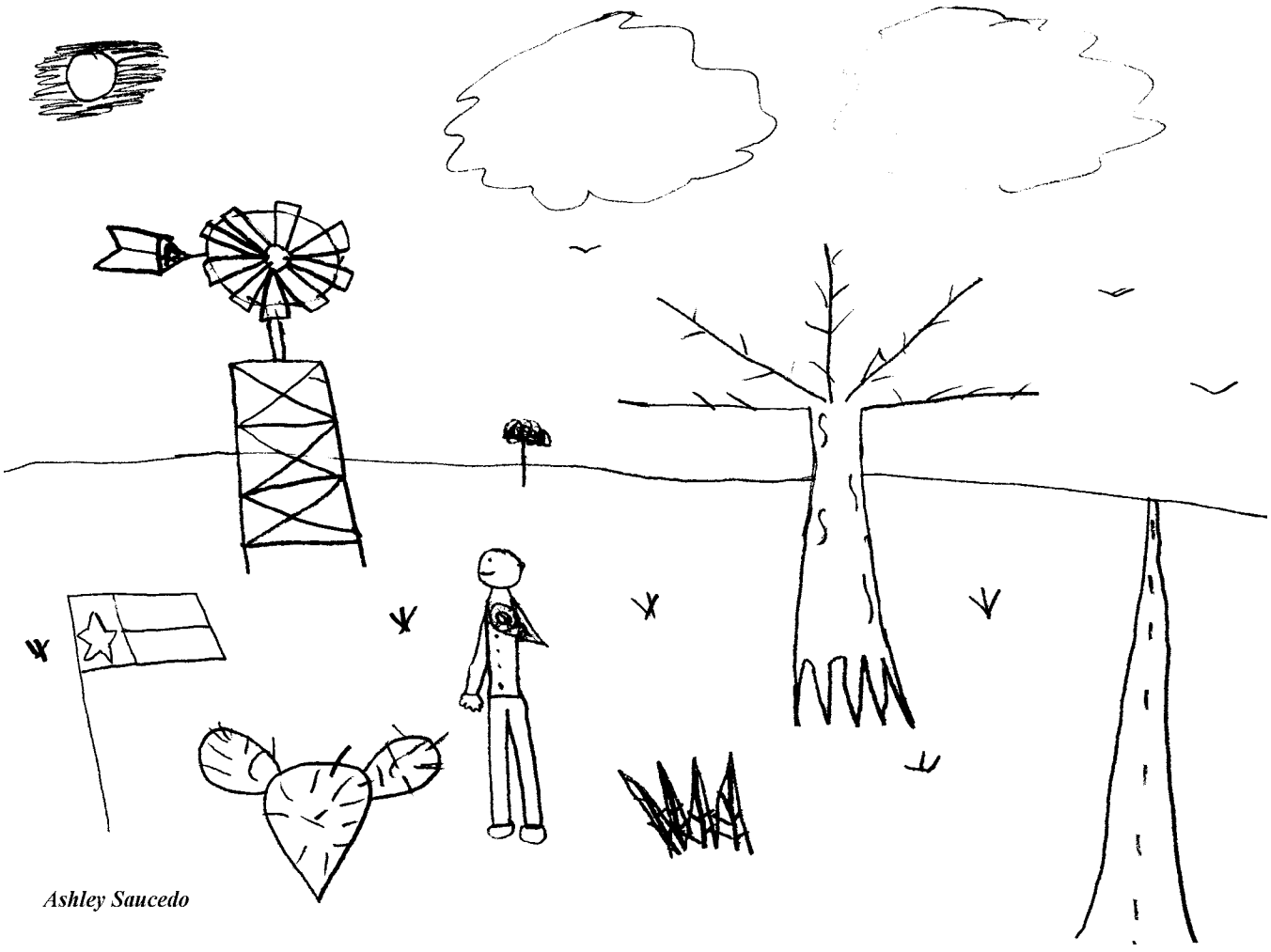

*Ashley Saucedo*

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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# IN THIS ISSUE

# THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

## Appointments

**Appointments for January 7, 2011**

Appointed to the Texas Appraiser Licensing and Certification Board for a term to expire January 31, 2012, Laurie C. Fontana of Houston (replacing Clinton Sayers of Austin whose term expired).

Appointed to the Texas Appraiser Licensing and Certification Board for a term to expire January 31, 2012, Shannon K. McClendon of Dripping Springs (replacing Robert Davis, Jr. of Coppell who resigned).

Appointed to the Risk Management Board for a term to expire February 1, 2015, Stephanie E. Simmons of Missouri City (replacing Kenneth Mitchell of El Paso who resigned).

**Appointments for January 10, 2011**

Appointed to the Texas Board of Professional Engineers for a term to expire September 26, 2015, Carry A. Baker of Amarillo (replacing Shannon McClendon of Dripping Springs whose term expired).

Appointed to the Texas Board of Professional Engineers for a term to expire September 26, 2015, Lamberto J. Balli of Houston (replacing Joe Cardenas of El Paso whose term expired).

Appointed to the Texas Board of Professional Engineers for a term to expire September 26, 2015, James A. Greer of Keller (Mr. Greer is being reappointed).

Appointed to the Public Transportation Advisory Committee, pursuant to HB 2218, 81st Legislature, Regular Session, for a term to expire at the pleasure of the Governor, Michelle L. Bloomer of Irving.

Appointed to the Public Transportation Advisory Committee, pursuant to HB 2218, 81st Legislature, Regular Session, for a term to expire at the pleasure of the Governor, Manuel Salazar, Jr. of Santa Anna.

**Appointments for January 11, 2011**

Appointed to the Texas Economic Development Corporation for a term at the pleasure of the Governor, Macedonio Villarreal of Sugar Land (replacing Tracye McDaniel of Houston who resigned).

Appointed to the Texas Commission on Fire Protection for a term to expire February 1, 2013, John T. McMakin of LaRue (replacing Micheal Melton of Gilmer who resigned).

Appointed to the Public Safety Commission for a term to expire January 1, 2016, A. Cynthia Leon of Mission (replacing Thomas Clowe, Jr. of Waco whose term expired).

Rick Perry, Governor

TRD-201100212

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# THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

## Request for Opinions

**RQ-0938-GA**

**Requestor:**

The Honorable Joseph Deshotel

Chair, Committee on Business and Industry

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether the assessment and analysis of information by a homeostasis analyzer constitutes the practice of medicine (RQ-0938-GA).

**Briefs requested by February 14, 2011**

**RQ-0939-GA**

**Requestor:**

The Honorable Veronica Gonzales

Chair, Committee on Border and Intergovernmental Affairs

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether the expanded definition of "disability" under federal law affects a taxpayer's qualification for the real property tax freeze on existing homesteads under Texas law (RQ-0939-GA).

**Briefs requested by February 14, 2011**

*For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.*

TRD-201100205

Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: January 18, 2011

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## Opinions

**Opinion No. GA-0834**

The Honorable Richard J. Miller

Bell County Attorney

Post Office Box 1127

Belton, Texas 76513

Re: Whether a local governmental body subject to the Public Funds Investment Act, chapter 2256, Government Code, may invest in money market and other demand accounts (RQ-0895-GA).

**S U M M A R Y**

While a local governmental body may "invest" its funds in money market deposit accounts under chapter 2256, Government Code, the Public Funds Investment Act, those funds are governed, when they exceed the maximum amount insured under federal law, by chapter 2257, Government Code, the Public Funds Collateral Act.

*For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.*

TRD-201100206
Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: January 18, 2011

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# PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

**Symbols in proposed rule text**. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

## TITLE 28. INSURANCE

## PART 1. TEXAS DEPARTMENT OF INSURANCE

### CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

### SUBCHAPTER X. PREFERRED PROVIDER PLANS

**28 TAC §§3.3701 - 3.3713**

The Texas Department of Insurance (Department) proposes amendments to §§3.3701 - 3.3706 and new §§3.3707 - 3.3713, concerning preferred provider benefit plans and network adequacy requirements. These amendments and new sections are necessary to implement SECTION 2 of House Bill (HB) 2256, enacted by the 81st Legislature, Regular Session, effective June 19, 2009, and HB 1030, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. HB 2256 adds new §1301.0055 to the Insurance Code and requires the Commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. HB 1030 mandates that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. In addition to implementing HB 2256 and HB 1030, these new and amended sections are necessary to: (i) ensure reasonable accessibility and availability of preferred provider services to Texas residents as provided in the Insurance Code §§1301.005, 1301.006, and 1301.007; and (ii) establish standards that support the use of preferred provider benefit plans that are not unjust under Chapter 1701, unfairly discriminatory under Chapter 544, Subchapters A and B, or in violation of Chapter 1451, Subchapters B and C, concerning designation and selection of providers. The new and amended sections also require the provision of consumer information in a manner consistent with the requirements of SECTION 11 of Senate Bill (SB) 1731, enacted by the 80th Legislature, Regular Session, effective September 1, 2007. The proposed amendments also update statutory references resulting from the nonsubstantive revision of the Insurance Code and Occupations Code and amend existing text for clarification, correct punctuation and grammar, and correct and update internal references.

As preparation for this proposal, the Department has solicited extensive feedback from stakeholders. To obtain comments, the Department made an informal posting on its website of a concept paper and proposed revisions to the rules governing preferred provider benefit plans on April 23, 2010. The Department held a meeting to discuss the drafts on May 5, 2010. After consideration of comments received, the Department made a second informal posting on its website of proposed revisions to the rules and an estimate of anticipated costs to comply with the revised rules on September 13, 2010. In making the posting, the Department requested comments on the substance of the draft rules, the accuracy of the Department's estimates of costs to comply with the draft rules, and input on what costs certain draft provisions would entail. A second informal stakeholder meeting was held to discuss the draft rules and potential costs on September 21, 2010.

Implementation related to network adequacy. The Insurance Code §1301.005 requires that an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area. Section 1301.005 further mandates that if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider. Additionally, the Insurance Code §1301.006 requires that insurers contract with sufficient providers to ensure that all covered services will be provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. Title 28 Texas Administrative Code Chapter 3, Subchapter X, contains the existing adopted sections governing preferred provider benefit plans.

The bill analysis for HB 2256 includes the following statement of intent: *"Balance billing is the practice of physicians billing patients for the portion of medical expenses not covered by the patient's insurance. Most commonly, this occurs when a facility-based physician does not have a contract with the same health benefit plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency is ultimately responsible for an unexpected bill. Currently, there is no remedy for this bill other than the patient attempting to set up a payment plan with the facility-based physician."* TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, "Author's/Sponsor's Statement of Intent") HB 2256, 81st Leg., R.S. (May 22, 2009). One of the remedies provided in HB 2256

for the problem of unexpected balance bills is the addition of §1301.0055 to the Insurance Code in SECTION 2 of the bill, mandating the Commissioner to adopt by rule network adequacy standards The proposed amended and new sections address the issues of network adequacy and unexpected balance billing in several ways: (i) the amendment and addition of network requirements; (ii) the amendment and addition of disclosure requirements; (iii) the amendment and addition of contracting requirements; and (iv) the addition of requirements concerning payment of certain out-of-network (basic benefit) claims.

*Network adequacy: network requirements.* The Department has addressed network requirements as required by the Insurance Code §1301.0055 and as further authorized under the Insurance Code §1301.007. Proposed new §3.3704(e) imposes specific network requirements that each preferred provider benefit plan must include in the health care service delivery network that supports the plan. The Department has adapted the network requirements to reflect the rural or nonrural nature of the service area, the nature of the services as routine, urgent, or emergency care, and the type of physician or provider that furnishes the services. Because the need for an adequate network is ongoing, proposed new §3.3704(f) requires insurers to monitor compliance with these network requirements on an ongoing basis and to take any needed corrective action as required to ensure that the network is adequate.

The Department proposes new §3.3706(a)(5) to prohibit the selection standards used by an insurer from: (i) avoiding high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or (ii) excluding a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or health services utilization. This prohibition is necessary to ensure that insurers afford all providers a fair, reasonable, and equivalent opportunity to apply to be and be designated as preferred providers, as required by the Insurance Code §1301.051. The prohibition is also consistent with the requirement in the Insurance Code §1301.058 that any economic profiling of physicians and providers by insurers be adjusted to recognize the characteristics of a provider's practice that may account for variations from average costs. Additionally, the prohibition ensures that the health insurance policy providing for the use of preferred providers is not unjust under the Insurance Code §1701.055(a)(2). It is the Department's position that a health insurance policy providing for different levels of benefits depending upon the use of preferred providers would not be just if selection criteria for preferred providers discriminated against the types of providers that are most particularly necessary for those insureds that present a risk of higher than average claims or health care services utilization. The prohibition is necessary to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided are accessible and available as specified in the Insurance Code §1301.006. The Department further proposes new §3.3706(c) to require insurers to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. The credentialing standards must, at a minimum, meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Additionally, there shall be a presumption of compliance with credentialing requirements if the insurer has received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, the URAC, or the Accreditation for Ambulatory Health Care. Proposed new §3.3706(c) will ensure that the service delivery network of preferred providers is appropriately qualified to provide the benefit package required under the health insurance policy, a necessary requirement in a policy that provides for different levels of coverage depending upon the use of preferred providers. The Insurance Code §1301.006 requires insurers to contract with sufficient physicians and providers to ensure "availability of and accessibility to adequate personnel, specialty care, and facilities." It is the Department's position that the use of a process for the selection and retention of physicians and providers that are appropriately credentialed is necessary to meet the adequacy requirement of §1301.006. It is also the Department's position that the requirement is necessary to ensure that the policy is just as contemplated in the Insurance Code §1701.055(a)(2).

Proposed §3.3707 specifies the manner by which an insurer may request a waiver from one or more network adequacy requirements due to local market conditions. An insurer may seek such waiver upon a showing that providers or physicians necessary for an adequate network are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable. Proposed §3.3707(b) further requires an insurer submitting a waiver request to submit a copy of the request to any provider or physician named in the request by any reasonable means and maintain evidence that such submission has been made. Proposed §3.3707(c) permits such provider or physician to electively submit a response to the waiver request. These provisions are necessary to permit the Department to fully consider the circumstances that the insurer asserts to support a waiver request. To limit the negative impact on insureds of plans operating without a supporting network that complies with network adequacy requirements, proposed §3.3707(a) also provides that the Department may impose reasonable conditions on the grant of such waiver. As required by the Insurance Code §1301.0055(3), proposed §3.3707(d) requires that upon such waiver being granted, the Department shall post on the Department's Internet website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area. To ensure that such a waiver does not continue indefinitely despite potential changes in the circumstances that originally supported the waiver, proposed §3.3707(e) requires that the insurer apply for renewal of the waiver annually. Physicians and providers will have an opportunity to furnish information in opposition to the request each year that the insurer applies for renewal of the waiver.

Proposed new §3.3709 requires insurers to file a network adequacy report with the Department on or before April 1 of each year and prior to marketing any plan in a new service area. Each report must specify the trade name of each plan in which insureds currently participate, the applicable service area of each plan, and whether the preferred provider service delivery network supporting each plan is adequate under the standards specified in §3.3704. Annual reports must include additional demographic information on the basis of specified geographic regions. This information includes the number of: (i) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level; (ii) claims for basic benefits paid at the preferred benefit coinsurance level; (iii) complaints by nonpreferred providers; (iv) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or

concerning balance billing; (v) complaints by insureds relating to the availability of preferred providers; and (vi) complaints by insureds relating to the accuracy of preferred provider listings. Data collected by the Department indicates that insurers do not closely monitor some important network adequacy indicators. For example, a majority of health benefit plan issuers reported that they do not separately monitor balance billing complaints and inquiries. See *Report of the Health Network Adequacy Advisory Committee: Health Benefit Plan Provider Contracting Survey Results, April 2009 (April 2009 Network Report)* at 4, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork409b.doc. Further, less than half of the surveyed health benefit plan issuers reported that they have a process for monitoring the extent to which insureds receive treatment from out-of-network (nonpreferred) facility-based physicians at in-network (preferred provider) facilities. *April 2009 Network Report* at 4. The information required to be reported under §3.3709 will encourage insurers to more closely monitor these important network adequacy indicators. In conjunction with TDI complaint data, the information will also facilitate the Department's oversight of compliance with network adequacy requirements on an ongoing basis in order to determine if additional examination of particular insurers is necessary. If the insurer does not use a service delivery network that complies with §3.3704, the insurer is required to submit an access plan as part of the annual report. The access plan must include for each service area that does not meet the network adequacy requirements: (i) the geographic area in which a sufficient number of preferred providers are not available, including a specification of the type of provider that is not sufficiently available; (ii) a map identifying the geographic area in which such health care services and/or physicians and providers are not available; (iii) the reason(s) that the preferred provider network does not meet the adequacy requirements; (iv) the procedures that the insurer will use to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and (v) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708. In addition to the access plan, insurers are required under proposed §3.3709(f) to establish and implement documented procedures for use in all service areas for which an access plan is submitted. Such procedures are required to identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer, furnish to such insureds a pre-service estimate of the amount the insurer will pay the physician or provider, and notify the insured that the insured may be liable for balance bill amounts. The insurer must also have a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured and make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. Access plans may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible. Proposed new §3.3709(h) specifies that the annual network adequacy report must be filed electronically in a format acceptable to the Department at a specified e-mail address. Additionally, proposed new §3.3709(i) requires insurers to establish an access plan within 30 days of the date on which a network no longer meets the adequacy requirements established in §3.3704. Such access plan is required to be made available to the Department upon request. Collectively, the requirements specified in proposed §3.3709 are necessary to permit ongoing monitoring of insurer compliance with network adequacy standards specified in the subchapter by the Department and to ensure that insurers are taking reasonable steps to reduce the potential scope of unanticipated balance bills. Further, it is the Department's position that the Insurance Code §1301.005 and §1301.069 contemplate that there will be instances in which insureds are seen by nonpreferred physicians or providers due to the inadequacy of an insurer's network. Section 1301.005(b) requires that insurers pay such claims at the preferred benefit level of reimbursement, and §1301.069 requires that such claims be paid promptly. Proposed new §3.3704(f) ensures compliance with the Insurance Code §1301.005 by requiring insurers to proactively identify those areas in which networks are inadequate, and §3.3704(f) requires that insurers take steps to ensure that claims from nonpreferred providers under those circumstances are paid correctly. The additional provision of information from insurers concerning the reasons for the network's inadequacy and specifying the steps taken by the insurer to protect insureds faced with an inadequate network will facilitate the Department's determinations of what regulatory response is most appropriate to address an insurer's use of an inadequate network in support of its preferred provider benefit plan.

The Department proposes new §3.3710 to address an insurer's failure to provide an adequate network. Proposed §3.3710 provides that if the Commissioner determines, after notice and opportunity for hearing, that the insurer's preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the Commissioner may order one or more specified sanctions. Under the Commissioner's authority to issue cease and desist orders as specified in the Insurance Code Chapter 83, proposed §3.3710(a) specifies that such sanctions may include an order to: (i) reduce the service area; (ii) cease marketing in parts of the state; and/or (iii) cease marketing entirely and withdraw from the preferred provider benefit plan market. Proposed §3.3710 is necessary to apprise insurers of potential sanctions that may result from the insurer's failure to provide an adequate network.

Proposed new §3.3711 defines 11 geographic regions by ZIP Code designations. The designation of regions will facilitate the required disclosure of specified demographic information as required under §3.3705(b)(14) for those plans that are offered on a less than statewide basis to permit the comparison of information among plans for prospective and current policyholders. The designation of regions also facilitates the provision of demographic information submitted by insurers as part of the annual network adequacy report as required in proposed §3.3709(c) and aids the Department's efforts to monitor network adequacy throughout the state. The designated regions correspond to public health regions established by the Department of Health and Human Services and are familiar to insurers. The regions also correspond to regions adopted separately by the Department in Texas Administrative Code §21.4504 for use by insurers in providing health care rate reimbursement data to the Department pursuant to the Insurance Code §38.355.

Proposed new §3.3712 specifies professional services for which insurers must require public disclosure of billed charges under §3.3703(a)(26)(B)(i). The use of a defined minimum data set for the disclosure will facilitate comparison by insureds. Addition-

ally, the data set corresponds to those professional services for which health care reimbursement data collection is performed under the Insurance Code §38.355. See Form No. LHL616 (Health Care Claims Reimbursement Rate Report), adopted by reference in 28 Texas Administrative Code §21.4507. The Department anticipates that the use of a comparable data set for the billed charges of physicians may additionally facilitate the mediation of some claims as permitted under the Insurance Code §1467.051(a).

*Network adequacy: disclosure requirements.* The Department proposes to amend and increase the disclosure requirements with which an insurer must comply to ensure that prospective and current insureds considering the purchase or renewal of coverage that relies upon the network have access to information that conveys the scope and limitations of the plan's ability to ensure the availability and accessibility of preferred benefit services.

Proposed new §3.3704(g) specifies the manner in which an insurer may define a preferred provider benefit plan's service area to provide for a clear delineation of a plan's boundaries for review by insureds. This delineation will facilitate an insured's ability to identify the service area in which preferred benefits are available and additionally permit comparison to the service areas of other plans. Collectively, this information will help prospective and current insureds to assess the network characteristics of a preferred provider benefit plan to determine if the plan is appropriate for the needs of the insured. Existing §3.3705(b)(12) requires an insurer to provide to a prospective or current group contract holder or insured on request: (i) a current list of preferred providers and complete network descriptions; and (ii) a disclosure of which preferred providers are not accepting new patients. The Department proposes to amend this paragraph to specify that this information may be provided electronically with the agreement of the insured provided that the insurer also furnishes the insured with information about how to obtain a non-electronic provider listing free of charge. This amendment will provide insurers with a less costly alternative for complying with the requirement based upon the insured's ability to access the information electronically. Further, the paragraph is consistent with the Insurance Code §1301.158(b) and §1301.159. Section 1301.158(b) requires insurers to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must include a current list of preferred providers. Section 1301.159 requires insurers to provide a current list of preferred providers at least annually. The Department also proposes an additional disclosure requirement in new §3.3705(b)(14). Proposed §3.3705(b)(14) will require insurers to provide current and prospective group contract holders or insureds with information regarding network demographics for each service area, if the plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of the subchapter if the plan is offered on a statewide service area basis.

The network demographic information must be updated at least annually and includes: (i) the number of insureds in the service area or region; (ii) the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an active access plan pursuant to §3.3709 of the subchapter applies to the services furnished by particular types of provider in the service area or region and how such access plan may be obtained or viewed, if applicable; (iii) the percentage of preferred providers that are accepting new patients; (iv) the percentage of preferred providers with board certifications in the area of practice, as applicable; (v) the number of preferred provider hospitals in the service area or region and the ratio of insureds to hospital beds, as well as an indication of whether an active access plan pursuant to §3.3709 applies to hospital services in the service area or region and how the access plan may be obtained or viewed; (vi) the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and (vii) the average surgical site infection rate at each specific preferred provider hospital in the service area or region. Disclosure of this network demographic information will assist current and prospective insureds and group contract holders to compare plans and to make informed decisions concerning the selection or retention of a plan. Further, such information will assist the insureds and group contract holders to more accurately assess the risk of unanticipated balance bills associated with reliance upon a particular plan and the network that supports such plan. The Department proposes additional required disclosures at §3.3705(e) for insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds. Such insurers are required to provide: (i) an Internet-based provider listing for use by current insureds, consistent with the requirements of the Insurance Code §1301.0591; (ii) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county, or ZIP Code area the insurer's determination that its network does or does not meet the network adequacy requirements of 28 Texas Administrative Code, Chapter 3, Subchapter X; and (iii) an Internet-based listing of the information specified for disclosure in §3.3705(b). Section 3.3705(b) addresses the insurer's required disclosure of terms and conditions of the policy to current and prospective insureds and group contract holders on request to permit comparison and informed decision-making concerning the selection or retention of a health care plan. The additional inclusion of that information on the insurer's website, in conjunction with the other specified disclosures, will facilitate such comparison and informed decision-making. The Department proposes new §3.3705(f) to require insurers to include a notice concerning rights of insured participants in preferred provider benefit plans in all policies, certificates, and outlines of coverage.

The content of the required notice is prescribed in Figure 28 TAC §3.3705(f) and addresses: (i) rights to an adequate network of preferred providers, consistent with the Insurance Code §1301.005(a); (ii) rights to file a complaint with the Department concerning an inadequate network, consistent with the Insurance Code §1301.161; (iii) rights to reimbursement of claims at preferred benefit levels if services were received from a nonpreferred provider due to a lack of reasonably available preferred providers, consistent with the Insurance Code §1301.005(b); (iv) rights to obtain a current listing of preferred providers and to obtain assistance in locating available preferred providers, consistent with the Insurance Code §1301.006 and §1301.159; (v) rights to reimbursement of claims at preferred benefit levels if the listing of preferred providers relied upon by the individual in seeking preferred providers is inaccurate, consistent with §3.3705(k); (vi) notice about the potential for balance billing by nonpreferred providers, as required by the Insurance Code §1456.003(b)(1); (vii) rights to advance estimates of bills from physicians and providers and of payment for services from insurers, consistent with the Health and Safety Code §324.101(d),

the Occupations Code §101.352(c), and the Insurance Code §1301.158(d) and §1456.007; and (viii) rights concerning mediation, consistent with the Insurance Code §1467.051(a) and §1467.053(d). Inclusion of the notice concerning these rights and facts is necessary to assist insureds and group contract holders to understand the several rights available to an insured both before and after the provision of services that affect, disclose, and potentially mitigate the scope of the insured's potential liability for balance bill amounts. Although not submitted by public counsel or specifically labeled as a "consumer bill of rights," this proposed notice of rights is similar to the bill of rights contemplated in the Insurance Code §501.156 for each personal line of insurance regulated by the Department. The Department proposes new §3.3705(h) - (j) to address in greater detail an insurer's obligations to provide information concerning preferred provider listings. Subsection (h) requires the insurer to notify all insureds at least annually of the manner in which the insured may access a current listing of all preferred providers on a cost-free basis. Minimum requirements for the notice include information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers. Insurers are required to maintain a toll-free telephone number to receive complaints and provide information as specified in the Insurance Code §521.102. Proposed new subsection (i) requires the insurer to ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months, consistent with the requirements in the Insurance Code §1301.159 and §1301.1591 concerning the annual provision of current preferred provider listings and the quarterly updating of preferred provider listings on the insurer's Internet website, respectively. Proposed new subsection (j) requires that if no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer is required to distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if such alternative method is agreed to by the insured, group policyholder on behalf of the group, or the certificate holder. To clarify the Department's position that an insured should be able to rely upon information recently obtained from an insurer or the insurer's designee concerning the status of preferred providers in accessing covered services at the preferred level of benefit, the Department proposes new §3.3705(k). Subsection (k) requires insurers to pay a claim for services rendered by a nonpreferred provider at the applicable preferred benefit coinsurance percentage if the insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider of the services is a preferred provider within the insurer's network. This requirement is necessary to ensure the reasonable accessibility and availability of preferred provider services as specified in the Insurance Code §1301.007. The Department has previously entered a consent order against one large insurer based on allegations that the insurer's listings of its contracted providers were not accurate. See *Commissioner's Order No. 08-0514,* June 13, 2008 at 3. It is the Department's position that if an insured reasonably relies an insurer's representation that a physician or provider is available to insureds as a preferred provider, but the physician or provider is, in fact, not contracted with the insurer, then the insurer has failed to make preferred provider benefits reasonably available to the insured. In such an instance, it is the Department's position that the insured is entitled to the protections of the Insurance Code §1301.005(b), which requires that the insurer reimburse a claim from a nonpreferred provider at the preferred benefit percentage level if services are not available through a preferred provider. Subsection (k) is also necessary to ensure that the underlying policy is not unjust in application, consistent with the requirements of the Insurance Code §1701.055(a)(2). The Department proposes additional listing-specific disclosure requirements at new §3.3705(l) for all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, as specified in paragraphs (1) - (11) of the subsection. Section 3.3705(l)(1) requires the insurer to include a method by which insureds may identify those hospitals that have contractually agreed with the insurer to: (i) exercise good faith efforts to accommodate requests from insureds to use preferred providers; and (ii) provide insureds with information sufficient to enable the insured to identify a facility-based physician or physician group that is assigned to provide services to the insured with enough specificity that the insured may determine the status of the physician or physician group as preferred or nonpreferred. The latter disclosure requirement would only reflect contractual agreements that apply to instances in which the physician or physician group is assigned at least 48 hours prior to services being rendered and would require that the responsive information be furnished to the insured at least 24 hours prior to services being rendered. Section 3.3705(l)(2) requires the insurer to include in its listings a method by which the insured may identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer by or on behalf of facility-based physicians, other than neonatologists and pathologists, are filed by or on behalf of a physician that is not under a contract with the insurer. Section 3.3705(l)(3) provides specificity concerning the requirement at subsection (l)(2) by clarifying that in determining whether a hospital meets the specifications in that paragraph, the insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information is furnished to the insured. Section 3.3705(l)(4) requires the insurer to indicate in each listing whether each preferred provider is accepting new patients. Section 3.3705(l)(5) requires the insurer to designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program. Section 3.3705(l)(6) requires the insurer to provide a method by which insureds may notify the insurer of inaccurate information in the provider listing, with specific reference to information about the provider's contract status and whether the provider is accepting new patients. Section 3.3705(l)(7) requires insurers to provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities. Section 3.3705(l)(8) requires the provider information to be furnished in fonts of not less than 10-point type. Section 3.3705(l)(9) requires the insurer to furnish provider information that specifically identifies those facilities at which the insurer has no contracts with a type of facility-based provider, specifying the applicable

type of provider. Section 3.3705(l)(10) requires the insurer to specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type. The particular requirements in §3.3705(l)(9) and (10) address the requirement of the Insurance Code §1456.003(c) for clear identification of those network (preferred provider) facilities in which facility-based physicians do not participate in the health benefit plan's provider network by providing for clear delineation of those facilities at which there is a greater or, alternatively, no risk of unanticipated balance bills from facility-based physicians. Section 3.3705(l)(11) requires the insurer to specify the date on which the information was provided to the insured in each provider listing. Collectively, these listing-specific disclosure requirements will facilitate the insured's ability to proactively seek out preferred provider services in nonemergency situations and to assess for future purposes the risk that some services may not be accessible through the insurer's preferred provider network. Data collected by the Department has indicated that approximately 10 percent of facility-based provider claims are from nonpreferred providers. *See April 2009 Network Report* at 3.

Because of the economic significance of the potential balance bills that an insured may receive for health care services of this nature, the information required to be provided in subsection (l) is necessary for insureds to make appropriate decisions about their care. Proposed new §3.3705(m) requires an insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 to notify all policyholders of this fact at issuance and at least 30 days prior to renewal of a policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes illustrating the affected service area. This information is necessary to facilitate comparison and informed decision-making with respect to the purchase or renewal of a policy by current and prospective policyholders. Proposed new subsection (n) requires an insurer to provide notice on the insurer's website of a substantial decrease in the availability of preferred facility-based physicians at preferred provider facilities. As specified in §3.3705(n)(1), a decrease is substantial if: (i) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at that facility terminates; or (ii) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination. Notice of the substantial decrease is not required if alternative preferred providers of the same specialty as the physician group that terminates a contract are made available to insureds at the facility, provided the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease. The notice of the termination and substantial decrease in availability of providers must be maintained on the insurer's website for six months from the initial posting or until adequate preferred providers of the same specialty become available to insureds at the facility.

Further, an insurer is required to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after the effective date of a contract termination between the insurer and physician group or the date on which the insurer receives notice of a contract termination between a physician group and a preferred provider facility. The notice requirements in proposed §3.3705(n) are necessary to place current and prospective policyholders on notice of the increased potential that services received at the preferred provider facility in question may include services from nonpreferred facility-based physicians and therefore include a greater risk of unanticipated balance bills. Armed with this information, insureds will have increased options to elect to receive services in preferred provider facilities at which there is a reduced likelihood that facility-based provider services will be furnished by nonpreferred providers as feasible. Proposed §3.3705(o) requires insurers to make certain disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services. Insurers must disclose how reimbursement of nonpreferred providers will be determined. If reimbursement is based upon data concerning usual, customary, or reasonable provider charges, the insurer must disclose: (i) the source of the data; (ii) how the data is used to determine reimbursements; and (iii) the existence of any applicable reductions. If reimbursement is based upon any amount other than full billed charges, the insurer must: (i) disclose that the insurer's reimbursement may be less than the billed charge; (ii) disclose that the insured may be liable to the nonpreferred provider for balance bill amounts; (iii) provide a description of the methodology used to determine the reimbursement amount; and (iv) provide a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service. In addition to educating insureds both generally and specifically concerning the potential for unanticipated balance bills, the Department anticipates that the provision of reimbursement methodology information may facilitate the insured's ability to mediate balance bill amounts owed to nonpreferred providers as contemplated in the Insurance Code §1467.054. Data collected by the Department indicates that insurers' allowable payment rates for nonpreferred providers varies significantly among insurers and by type of provider. *See Report of the Health Network Adequacy Advisory Committee,* January 2009 at 19, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc.

Additionally, the Department has entered a disciplinary order against one large preferred provider benefit plan insurer based on allegations that: (i) the insurer's policy documents did not adequately define how it would determine out of network (nonpreferred provider) facility reimbursements; and (ii) those reimbursements were unreasonably low in context with representations made in advertising and policy documents. *See Commissioner's Order No. 08-0514,* June 13, 2008, at 2. Based upon such information, the Department's position is that disclosure of the information required by proposed §3.3705(o) is important to insureds' understanding of their coverage. Proposed new §3.3705(p) authorizes insurers to designate preferred provider benefit plans using a network that complies with the network adequacy requirements for hospitals under §3.3704 without reliance upon an access plan as having an "Approved Hospital Care Network" (AHCN). A plan using a service delivery network that does not meet the requirements for hospitals under §3.3704 is required to disclose that the plan has a "Limited Hospital Care Network." The disclosure is required: (i) on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network; and (ii) on the cover page of any nonelectronic provider directory describing the network. Further, proposed new §3.3705(q) requires that a preferred provider benefit plan that is designated as an AHCN but loses its compliance status with the network adequacy requirements for hospitals notify the Department of such change if the noncompliant status is not

corrected within 30 days of the insurer becoming noncompliant. Such insurer is additionally required to cease marketing the plan as an AHCN and to inform all insureds of such change of status at the time of renewal. The designation, notice, and marketing requirements in proposed new §3.3705(p) and (q) will assist current and prospective policyholders to assess the risk that a plan will not have available and accessible facility-based physicians at preferred provider hospitals as the insured compares plans in determining whether to select or renew a policy. The requirements will additionally assist the Department to monitor network adequacy status and help to prevent inappropriate, misleading, or deceptive marketing. Proposed §3.3707(f) specifies that an insurer's receipt of a waiver for a plan under the section requires the insurer to designate such plan as having a "Limited Hospital Care Network." This requirement is necessary to ensure that prospective and current insureds understand the limitations of the plan's ability to ensure the availability and accessibility of preferred benefit services when considering the purchase or renewal of coverage that relies upon the network.

Proposed §3.3708(e) imposes a disclosure requirement on insurers that applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as identified in proposed §3.3708(a). In such case, the insurer is required to disclose with each explanation of benefits that the insured has the right to request three categories of reimbursement data in relation to the claim for comparison purposes: (i) the median per-service amount that the insurer has negotiated with preferred providers for the services furnished, or notification that the claim was paid at this amount; (ii) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers, or notification that the claim was paid at this amount; and (iii) the amount that would be paid under Medicare for the service. The disclosure amounts are calculated exclusive of cost sharing responsibilities of the insured. Section 3.3708(e) is proposed to apply effective January 1, 2012, and the Department proposes to provide for a six-month waiver process with respect to the disclosure in §3.3708(f). The disclosure is necessary to provide to insureds faced with the financial consequences of unanticipated balance bills that arise due to the need for emergency care or due to the failure of the insurer to provide an adequate network with information on request to evaluate the reimbursement made by the insurer and to determine whether to request mediation as permitted under the Insurance Code §1467.054 for eligible claims. Even if mediation is not available, the information provided by the insurer could greatly assist an insured who wishes to contest an alleged unreasonable balance bill by a nonpreferred provider by allowing the insured to compare the physician or provider's charge to the average rate other providers have agreed to with the insurer. The six-month waiver process is necessary to provide flexibility to insurers for which circumstances justify an extended period of time in which to comply with the new disclosure requirement.

The Department proposes a final disclosure requirement concerning the effects of uncompensated care upon health care costs in proposed §3.3713. Proposed §3.3713(a) is not effective until the expiration of seven years from the effective date of the section. At that time, insurers are required to initiate an annual reporting requirement that provides to the Department the following information: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility.

Effective at the expiration of eight years from the effective date of §3.3713, proposed §3.3713 requires insurers to make the information concerning the effects of uncompensated care as reported to the Department publicly available and to provide notice of the availability of such information in each policy, certificate, and outline of coverage. Proposed §3.3713(d) further requires that an insurer's contract with a facility contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required under §3.3713. Proposed §3.3713(a) - (d) is necessary to provide information to both the Department and the interested public concerning the relationship of uncompensated care to health care costs incurred by insurers and insureds. Information concerning the impact of uncompensated care upon health care fees and insurance premium rates will help insureds to educate themselves concerning possible barriers to improved networks of preferred providers and factors influencing health insurance premium rates. Proposed §3.3713(e) - (g) establish a six-month waiver process for the requirements of §3.3713 to provide flexibility to insurer's whose particular circumstances justify such delay.

*Network adequacy: contracting requirements.* The Department has addressed contracting requirements that will support increased availability and accessibility of preferred benefit services. The Department proposes to amend §3.3703(a)(4). Existing §3.3703(a)(4) provides that a contract between an insurer and a hospital or institutional provider shall not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. The Department proposes to limit this prohibition such that it applies more narrowly by phasing out the prohibition with respect to certain groups of physicians or practitioners over a five-year period. The proposed prohibition will not apply to physicians or practitioners that are members of a practice group that includes 15 or more physicians or practitioners after June 1, 2014. The prohibition will not apply to physicians or practitioners that are members of a practice group that includes at least seven and not more than 14 physicians and practitioners after June 1, 2016. However, the contracting prohibitions will remain effective with respect to practice groups of physicians or practitioners that have not previously held staff membership or privileges with a hospital or institutional provider and acquire such membership or privileges for the first three years of such membership or privileges. This latter limitation is intended to prevent the requirement from deterring the extension of new staff memberships and privileges. The Department's position is that the proposed amendment to §3.3703(a)(4) removes the contracting prohibition with respect to larger practice groups that are better positioned to bargain with insurers in connection with preferred provider contracts while retaining the prohibition with respect to those physicians and practitioners not as well-positioned to so bargain. In this way, those insurers not otherwise precluded from making use of such a contract provision will now be permitted to voluntarily seek through market negotiations to increase the number of contracted physicians and practitioners at the preferred provider hospitals and institutional providers that participate in the insurer's plan. Such a change will provide a basis from which insurers may improve accessibility and availability of preferred provider services to insureds under the plan while still affording a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners, institutional providers, and practitioners as required

under the Insurance Code §1301.051(a). The Department proposes new §3.3703(a)(23) to specify that a contract between an insurer and a preferred provider may contain a provision requiring a referring physician or provider, or a designee, to disclose specified information to the insured concerning the referral as applicable. Under proposed §3.3703(a)(23)(A), the referring physician or provider must disclose that the physician, provider, or facility to whom the insured is being referred is not a preferred provider. Under proposed §3.3703(a)(23)(B), the referring physician or provider must disclose that the referring physician or provider has an ownership interest in the facility to which the insured is being referred. Proposed §3.3703(a)(23) is permissive in nature and does not apply to contracts between insurers and institutional providers. The provision clarifies the Department's position that such contract provisions are permitted and benefits insureds by increasing the information furnished by referring physicians or providers. This additional information will afford the insured an opportunity to consider whether to seek referral to a preferred provider and thereby reduce the potential for unanticipated balance bills from nonpreferred providers. Proposed §3.3703(a)(24) further clarifies that, if used, a contract provision requiring disclosure of the nonpreferred status of the physician, provider, or facility to whom an insured is being referred is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care. The contract requirement also may not limit access to nonpreferred providers. Proposed §3.3703(a)(24) is necessary to ensure that the benefits of the disclosures made pursuant to such a contractual provision do not result in delay of medically necessary care or interfere with the insured's freedom to elect to receive basic benefit care from nonpreferred providers should the insured desire to do so. Proposed §3.3703(a)(25) requires that contracts between insurers and preferred providers include a requirement that the preferred provider comply with all applicable requirements of the Insurance Code §1661.005. Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. Proposed §3.3703(a)(25) will reinforce this statutory requirement and help to ensure that overpayments are promptly refunded to insureds, reducing unnecessary negative financial consequences associated from receipt of care from within the insurer's network of preferred providers, and providing an effective remedy for insureds alleging violations of §1661.005.

Finally, the Department proposes new §3.3703(a)(26) to impose new requirements for contracts between insurers and facilities. Under proposed §3.3703(a)(26)(A), such contracts must require the facility to give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer. This requirement is necessary to facilitate the insurer's ongoing responsibility to monitor the network(s) that support the insurer's preferred provider benefit plans for compliance with network adequacy requirements and take corrective action as needed. Under proposed §3.3703(a)(26)(B), contracts between insurers and facilities must require facilities to impose requirements upon facility-based physicians providing services at the facility. Specifically, such facility-based physicians must be required to: (i) make disclosure to the general public of the typical range of the physician's billed charges for professional services as specified in proposed §3.3712; and (ii) provide responsive information no more than annually to surveys of physician fees conducted by the Department or by an academic institution conducting the survey on behalf of the Department. This requirement will increase the information available to insureds to facilitate informed decision-making in the selection of facilities and facility-based physicians to the extent that such selection is possible. The Department anticipates that such informed decision-making will help to reduce the potential for unexpected balance bill amounts incurred by insureds who receive care at preferred provider facilities from physicians that are not preferred providers. Additionally, such information will permit insureds to more accurately assess potential personal liability for balance bill amounts in some instances if compared to an estimate of payments that will be made for a health care service or supply. An insurer is required to provide such an estimate on request pursuant to the Insurance Code §1456.007.

*Network adequacy: payment of certain basic benefit claims.* The Department proposes new §3.3708 to establish minimum standards for certain basic benefit claims. Proposed §3.3708 applies to services provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured, including circumstances: (i) requiring emergency care; (ii) when no preferred provider is reasonably available within the designated service area for which the policy is issued; and (iii) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider. In each of these circumstances, the insurer is required to pay the claim at the preferred benefit coinsurance level as required pursuant to the Insurance Code §1301.005(b) and §1301.155(b). Proposed new §3.3708(b)(2) also requires the insurer to credit out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. This requirement is intended to protect insureds who do not voluntarily choose to obtain services from nonpreferred providers by giving the insureds credit for their actual out-of-pocket expenses in the same manner they would receive such credit if they had received services from a contracted preferred provider. This is consistent with the intent of the Insurance Code §1301.005 and §1301.069, which provide that, if an insured obtains out of network services from a nonpreferred provider due to an inadequate network or an emergency, the insured is entitled to the preferred level of benefits.

Proposed new §3.3708(c) requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria. The methodology is required to: (i) be based on generally accepted industry standards and practices for determining customary billed charges for a service and to fairly and accurately reflect market rates, including geographic differences in costs, for those methods based upon usual, reasonable, or customary charges; (ii) be based on sufficient data to constitute a representative and statistically valid sample, if based on claims data; (iii) be updated at least annually; (iv) not to use data that is more than three years old; and (v) be consistent with nationally recognized and generally accepted bundling edits and logic. The reimbursement standards in proposed §3.3708 are necessary to ensure that preferred provider benefit plan policies are offering meaningful reasonable availability of basic benefits covered under the benefit package as specified in the Insurance Code §1301.005(a). It is the Department's position that establishment of unreasonably low reimbursement rates for basic services creates a barrier to

the reasonable availability of basic services in a manner that is inconsistent with §1301.005(a) and that renders the underlying policy unjust under the Insurance Code §1701.055(a). The standards established in proposed §3.3708(c) will help to ensure that reimbursement rates are based upon relevant, current, and statistically valid data in order to mitigate the potential unexpected balance billing to which insureds are subjected as a result of health care emergencies and inadequate networks. The standards will give physicians, providers, and insureds greater confidence that the methodologies underlying reimbursement determinations are appropriate, and that terms used in preferred provider benefit plan documents will have consistent meanings as applied by different insurers, as well as provide the Department clear standards to apply when reviewing the appropriateness of reimbursement methodologies used for nonpreferred providers. Proposed new §3.3708(d) requires insurers to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan. This provision is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005 by limiting coverage to those services provided within the designated service area. It is the Department's position that imposition of such a restriction by an insurer would reduce the insured's access to basic level services in a manner that would render the policy unjust as contemplated in the Insurance Code §1701.055(a)(2).

Implementation related to HB 1030. In connection with HB 1030, the Department proposes an amendment to §3.3704(a)(6). Existing §3.3704(a)(6) specifies that: (i) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 30 percent less than the higher level of coverage; and (ii) a reasonable difference in deductibles is determined considering the benefits of each individual policy. HB 1030 amends the Insurance Code by adding §1301.0046 to mandate that the insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Proposed §3.3704(a)(6) updates the specifications of the paragraph for greater consistency with this statutory requirement.

Changes to update and clarify. The Department proposes additional amendments to reflect and clarify the reorganized and updated content of the subchapter, including applicability. Existing §3.3701(a) is subdivided into two subsections to address the prospective application of the proposed subchapter to policies delivered, issued for delivery, or renewed on or after June 1, 2011, and the remaining subsections are redesignated accordingly. The proposed amendment to §3.3701(d), redesignated as §3.3701(e), updates the language concerning the severability of the subchapter's provisions and applications to clarify the scope of such severability. The Department proposes amendments to §3.3702 to add definitions for words and terms used in proposed amendments to the subchapter to clarify the scope of such usage. These proposed words and terms include: (i) *billed charges* at paragraph (1); (ii) *facility* at paragraph (4); (iii) *facility-based physician* at paragraph (5); (iv) general practitioner at paragraph (6); (v) NCQA at paragraph (13); (vi) nonpreferred provider at paragraph (14); (vii) *pediatric practitioner* at paragraph (15); (viii) *rural area* at paragraph (22); (ix) *specialist* at paragraph (24); and (x) *urgent care* at paragraph (25).

Existing paragraphs of §3.3702 are proposed to be redesignated accordingly. The proposal includes new catchlines in each subsection of §3.3704 to better reflect the organization and content of the section with respect to fairness requirements, payment of nonpreferred providers, prohibited retaliatory action, access to certain institutional providers, network requirements, network monitoring and corrective action, and service areas. The Department proposes to delete existing §3.3704(a)(10), which provides that if covered services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. The existing paragraph also specifies that the section does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience. Because the paragraph is largely duplicative of statutory language in the Insurance Code §1301.005(b) and (c), the Department has determined that retention of the paragraph in this subsection is unnecessary.

The remaining paragraphs in §3.3704(a) are redesignated accordingly. The Department proposes to amend the title of §3.3705 to better reflect the content of the section. The proposed amendment revises the title to "Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations."

Further, the Department proposes to add catchlines to existing subsections (a) - (d) of §3.3705 to better reflect the content of those subsections concerning readability, disclosure of terms and conditions of the policy, filing requirements, and promotional disclosure requirements. The Department proposes to amend §3.3705(b)(12) by deleting the term "and" at the end of paragraph due to the proposed addition of a paragraph to the subsection. A proposed amendment to §3.3705(b)(13) recognizes that an insurer may have more than one service area and accommodates an additional paragraph proposed in the subsection by substituting a semi-colon and the word "and" for the period at the end of the paragraph. As part of the reorganization of the content of §3.3705, existing subsection (e) is redesignated as subsection (g), and a catchline is added to the subsection to reflect that the subsection addresses the prohibition on the distribution of untrue or misleading information. The Department proposes to delete existing §3.3705(f), concerning the distribution and filing of current lists of preferred providers. The distribution of such lists is addressed in proposed new §3.3705(h) - (j). Filing requirements concerning preferred provider listings are addressed and updated in the proposed amendment to §3.3705(c). This proposed amendment permits the filing of such provider listings to be made electronically at a specified email address in a format acceptable to the Department or by submission of an Internet website address at which the Department may view the listing. For carriers choosing to file the listings nonelectronically, the proposed amendment additionally specifies the address to which nonelectronic filings are required to be submitted. The Department also proposes to delete existing §3.3705(g), which specifies that insurers must provide to each insured a toll-free number to be maintained 50 hours per week during business hours that the insured may call to obtain current listings of preferred providers, unless exempted by statute or rule. The provision of this information is addressed in proposed new §3.3705(h).

To better reflect the organization and content of §3.3706, the Department proposes to amend existing subsections (a) and (b) to add catchlines to emphasize that the subsections address ac-

cess to designation as a preferred provider and withholding preferred provider designation, respectively. The Department proposes to redesignate existing subsections (c) and (d) as subsections (d) and (e), respectively, to accommodate the addition of new proposed subsection (c). The Department further proposed to add catchlines to the subsections to emphasize that the subsections address notice of termination of a preferred provider contract and review of a decision to terminate. The Department proposes to redesignate existing §3.3705(d)(3) as subsection (f) and to add a catchline to the subsection to emphasize that the subsection addresses completion of the review process. The Department proposes to redesignate existing subsection (e) as subsection (g), accordingly, and to add a catchline to the subsection to emphasize that the subsection addresses the expedited review process. The Department proposes to redesignate existing subsection (e)(3) as subsection (h) and to add a catchline to the subsection to emphasize that the subsection addresses completion of the expedited review process. The Department further proposes to redesignate existing subsections (f) and (g) as subsections (i) and (j), respectively, to accommodate the addition of subsections to the section. The Department also proposes to amend §3.3706(a) by adding the phrase "subject to subsection (b) of this section" to clarify the manner in which the two subsections are intended to work together. Proposed amendments throughout the rule update statutory references that have changed as a result of the legislature's nonsubstantive reorganization of the Insurance Code and Occupations Code.

These updates are made in proposed §§3.3701(c); 3.3702(3), (7) - (12), (16) - (21), (23) and (26); 3.3703(a)(11) - (15), (17), and (18), (b), and (c)(1) and (2); and 3.3704(a), (a)(1), (4), (5), and (9), and (d). Amendments to update or provide greater specificity concerning internal references in the subchapter are proposed at §§3.3703(a)(8) and (19); 3.3704(a)(10); 3.3705(a); 3.3706(d)(2); and 3.3706(j)(2). Additional amendments for clarity, ease of reading, and correction of punctuation, capitalization, and grammar are proposed throughout the rule, as well. These proposed amendments appear in §§3.3701(c) and (d); 3.3702(3), (7) - (12), (16) - (21), (23), and (26); 3.3703(a), (a)(1) - (3), (5) - (20), (20)(A), (20)(A)(i) and (iii), (20)(B) - (D), (F), (G)(i)(I) - (IV), and (H), and (22), (b), and (c)(1) and (2); 3.3704(a), (a)(1) - (6), (8) and (9), (b) - (d); 3.3705(a), (b), (b)(9), (c) and (d); and 3.3706(a), (a)(1) - (4), (b), (b)(1) and (2), (2)(A) - (E), (d), (d)(2), (e), (e)(1), (f), (g), (i), (i)(1) and (2), (j), and (j)(1) - (3).

FISCAL NOTE. Mr. Doug Danzeiser, Deputy Commissioner for Regulatory Matters, Life, Health and Licensing Program, has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Mr. Danzeiser also has determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the enforcement and administration of this proposal, as well as potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits consistent with the authorizing statutes while mitigating costs.

ANTICIPATED PUBLIC BENEFITS. The public benefits anticipated as a result of the proposal relate primarily to network adequacy and improvements in information available to consumers. With respect to network adequacy, the following public benefits are anticipated: (i) the establishment of standards for the Department's evaluation of the preferred provider networks supporting preferred provider benefit plans; (ii) improved access to and availability of preferred providers for insureds; (iii) the establishment of a standardized reporting process for insurers concerning the network adequacy of preferred provider benefit plans in Texas; (iv) the establishment of a waiver process for network adequacy requirements in accordance with the requirements of the Insurance Code §1301.0055(3); and (v) standards for the payment of out of network (basic benefit) claims. With respect to improved transparency of information available to consumers, the following public benefits are anticipated: (i) greater availability of more standardized network demographic information and other health plan information to permit prospective and current insureds to be able to better compare plans in determining whether to select or retain coverage using a particular network; (ii) greater availability of consumer information for assessing the risk of receiving services from nonpreferred providers at preferred provider facilities, and therefore the risk of experiencing unanticipated balance bills; (iii) greater availability of information concerning typical billed charges for possible use in the selection of physicians and facilities or in contesting billed charges from nonpreferred providers; (iv) greater transparency concerning the rights of an insured before and after the provision of services that may affect, disclose, and potentially mitigate the scope of the insured's potential liability for balance bill amounts; and (v) improved information for consumers to use in the selection of preferred providers. Additional benefits of the proposal include clarification of the Department's position on the permitted inclusion of certain contractual provisions in preferred provider contracts and increased consistency with the requirements of HB 1030, enacted by the 79th Legislature, Regular Session, effective September 1, 2005.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL. On September 13, 2010, the Department posted a second informal draft of proposed network adequacy rules and an estimate of anticipated costs to comply with §§3.3703 - 3.3710. The Department sought comments on the substance of the draft rules, on the accuracy of the Department's estimates of costs of compliance, and input on what costs certain provisions would entail. A second informal stakeholder meeting was held to discuss the draft rule and potential costs on September 21, 2010. Except as otherwise noted in this cost analysis, the Department did not receive information from any stakeholders concerning the cost information included in the Department's informal posting. The Department did receive general input that the cost of compliance would be significant.

Mr. Danzeiser estimates that there could be potential costs to insurers required to comply with several of the proposed amendments and new sections during each year of the first five years that the rules will be in effect. The Department has identified eight sections of the proposal that may result in compliance costs only for insurers that offer preferred provider benefit plans. These sections are: (i) proposed §3.3703 concerning contract requirements; (ii) proposed §3.3704 concerning network adequacy requirements; (iii) proposed §3.3705 concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations; (iv) proposed §3.3706 concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process; (v) proposed §3.3707 concerning waiver requirements due to failure to contract in local markets; (vi)

proposed §3.3708 concerning payment of certain basic benefit claims and related disclosures and waivers; (vii) proposed §3.3709 concerning the annual network adequacy and access plan reports; and (viii) submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements. This cost note analysis addresses the cost of compliance with these eight sections for an insurer that undertakes steps necessary for compliance on its own behalf.

*Use of a PPO network to achieve compliance.* The Department anticipates that insurers could alternatively contract with one or more independent preferred provider organization networks (PPO networks) such that the PPO network(s) assume primary responsibility for undertaking one or more of the steps necessary to comply with this proposal. Under this alternative, while it remains the responsibility of the insurer to either meet the requirements or ensure that the requirements are met in accordance with §3.3703(c), the factors and components affecting the cost of compliance with the requirements would necessarily vary for each requirement. The Department estimates that this variation will be based upon the size of the network(s) used by each insurer, the scope of the underlying contract between the insurer and the PPO network, and the fees charged by the PPO network for performance of the contract. Each individual insurer that uses or considers the use of this method of achieving compliance with some or all of the provisions of this proposal has or may obtain the information necessary to assess these factors and to determine its resulting anticipated costs of compliance.

*Pass-through costs from physicians and providers.* The Department further anticipates that the contracting process used by insurers with some physicians and providers could reflect increased preferred provider fees based upon the increased requirements of the underlying preferred provider contract. It is not possible for the Department to estimate the amount of such pass-through costs because there are numerous factors involved in setting contract reimbursement rates that are not suitable to reliable quantification.

I. Costs concerning contract requirements.

*Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred providers and of ownership interests in facilities to which the insured is being referred.* Proposed new §3.3703(a)(23)(A) and §3.3703(a)(23)(B) specify that a contract between an insurer and a non-institutional preferred provider may contain provisions at the insurer's option requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or provider has an ownership interest in the facility to which the insured is being referred. If insurers elect to include the contract provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) in contracts with non-institutional providers, the Department anticipates that insurers may incur costs associated with drafting new contracts or amendments to existing contracts. The Department estimates that the total cost for an insurer that opts to include the contract provisions may involve cost components including the following: (i) cost of administrative staff wages necessary for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments.

*(i) Cost of administrative staff wages for drafting and basic review.* The Department anticipates that, because the proposed required provisions will likely require little or no modification from the proposed rule text, an insurer's administrative staff will do most if not all of the drafting and basic review of new contracts or amendments to existing contracts. The Department anticipates that this drafting will likely require on average less than one hour administrative staff time per contract modified. The cost to an insurer may vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, review the new or amended contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission, Labor Market and Career Information Department, Occupation & Employment Statistics Estimate Delivery System (hereafter referred to as the Texas Workforce Commission OES Report), available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=11-1021&compare=2.
An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=43-6011&compare=2. The Department therefore estimates that an insurer could incur an average annual cost of staff wages for drafting and basic review of contracts of less than $57.96 per contract, with anticipated variation depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, draft and review the new or amended contract language templates. The cost could also vary depending upon whether the contracting practices of an insurer require review of multiple or single contract templates, the extent to which contracts vary, and, if multiple contract templates or unique contracts are used, the number of such templates or unique contracts.

*(ii) Cost of legal staff.* The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding, each new contract or amendment of existing contracts that includes the provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). The Department anticipates that, because the proposed required provisions will likely require little or no modification from the proposed rule text, the legal review service from a lawyer will consist mainly of reviewing new or amended contracts drafted by the insurer's administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce Commission OES Report available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=23-1011&compare=2.
Therefore, the Department estimates that an insurer could incur an average annual cost of less than $51.11 in legal fees on average for each new or amended contract reviewed. The cost, however, for a particular insurer could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, and the number of such templates or unique contracts. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost

for contracting with an attorney in private practice for the legal review will likely vary from and could exceed the stated salaried hourly wage.

*(iii) Cost to print new contracts or amendments.* The Department anticipates that an insurer could incur a cost for printing new contracts or amendments to existing contracts in order to include contract requirements as specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). The Department estimates that this cost could range from approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that an insurer will need approximately one page per contract. The number of total pages will depend on the number of contracts the insurer chooses to amend. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(iv) Cost to transmit new contracts or amendments.* The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail to include the contract provisions specified in proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each contract or amendment of existing contracts that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract or per set of amendments of existing contracts. However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts or amendments, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or amendments to existing contracts would be incurred by an insurer that opts to transmit new contracts or amendments electronically. These costs would be part of the ongoing information technology equipment and service costs of the insurer.

Though the Department has identified factors attributable to the cost of compliance with proposed new §3.3703(a)(23)(A) and §3.3703(a)(23)(B), it is not possible for the Department to estimate the absolute total amount of compliance costs that an insurer could incur because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts.

*Proposed §3.3703(a)(25): Contract provision between an insurer and a preferred provider that mandates that a preferred provider comply with all applicable requirements of the Insurance Code §1661.005.* Proposed §3.3703(a)(25) specifies that a contract between an insurer and preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005, relating to refunds of overpayments from enrollees. (Note: Some statutory provisions referenced in this proposal use the term "enrollees" and some use the term "insureds"; but the Department interprets these two terms to have the same meaning for purposes of this proposal.) The Insurance Code §1661.005, effective May 30, 2009, mandates that a physician, hospital, or other health care provider that receives an overpayment from an enrollee refund such overpayment within 30 days of the date the determination an overpayment was made. Proposed new §3.3703(a)(25) mandates that this statutory requirement be included in any contract between an insurer and a preferred provider. The Department anticipates that proposed §3.3703(a)(25) could result in compliance costs for insurers. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) are applicable to estimating the cost for compliance with proposed §3.3703(a)(25). Because the cost is based on the same methodology and cost components as those determined for compliance with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B), the following is a summary of the Department's analysis (which is detailed in this Cost Note under the subheading for *"Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)"):* (i) cost of administrative staff wages for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments. Because this is a required contract provision, these costs will be incurred by those insurers required to comply with these rules that do not currently have such a provision in their contracts with preferred providers. However, the total cost for each insurer will depend largely on the size of an insurer's network(s) and its internal business practices, such as the extent to which an insurer negotiates individual contract terms on a case by case basis.

Though the Department has identified factors attributable to the cost of implementing §3.3703(a)(25), it is not possible for the Department to estimate the absolute total amount of compliance costs that an insurer could incur because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts.

*Proposed §3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii): Requirement that insurer include contract requirement that facilities give notice of termination of contracts with facility-based physician groups, require facility-based physicians to publicly disclose physician fees, and require facilities to respond to annual surveys of physician fees.* Proposed new §3.3703(a)(26)(A) specifies that a contract between an insurer and a facility must require the facility to give notice to the insurer as soon as reasonably practicable, but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer. Proposed new §3.3703(a)(26)(B)(i) specifies that a contract between an insurer and a facility must require the facility to mandate its facility-based physicians providing services at the facility to make disclosure to the general public of the typical range of the physician's billed charges for certain specified professional services. Proposed new §3.3703(a)(26)(B)(ii) specifies that a contract between an insurer and a facility must require the facility to mandate facility-based physicians providing services at the facility to provide responsive information no

more than annually to surveys of physician fees conducted by the Department or by an academic institution conducting the survey on the Department's behalf. The Department anticipates that proposed §3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii) could result in costs to comply for insurers. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) are applicable to estimating the cost for compliance with proposed §3.3703(a)(25). Because the cost is based on the same methodology and cost components as those determined for compliance with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B), the following is a summary of the Department's analysis (which is detailed in this Cost Note under the subheading for *"Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)":* (i) cost of administrative staff wages for drafting and basic review; (ii) cost of legal staff; (iii) cost to print new contracts or amendments; and (iv) cost to transmit new contracts or amendments. These costs may additionally vary as explained in the introduction to this cost analysis based upon the use of PPO networks to achieve compliance with proposed §3.3703(a)(25) or as a result of pass-through costs from physicians and/or providers. The Department notes that proposed §3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii) specify required contract provisions, and thus these costs will be incurred by most insurers; however, the total cost for each insurer will depend largely on the size of the network(s) used by an insurer and its internal business practices, such as the extent that an insurer negotiates individual contract terms on a case by case basis.

Though the Department has identified factors attributable to the cost of implementing §3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii), it is not possible for the Department to estimate the total amount of cost attributable to the paragraph because there are numerous factors involved that are not suitable to reliable quantification by the Department, including issues such as the size of the insurer's service area and the number of the insurer's existing preferred provider contracts. The Department also notes that in addition to the Department's determination of cost estimates for legal services necessary to administer and comply with proposed §3.3703(a)(26)(A), 3.3703(a)(26)(B)(i), and 3.3703(a)(26)(B)(ii), the Department received a cost estimate from one insurer of $800, or 40 hours at $20 per hour, for these legal services The Department anticipates that this cost will vary for each insurer. Each insurer, however, has the information necessary to estimate the insurer's cost for such legal services.

II. Cost to insurers concerning network adequacy requirements.

*Proposed §3.3704(e) and §3.3704(f): Network adequacy requirements, monitoring, and corrective actions.* Proposed new §3.3704(e) requires that each preferred provider benefit plan include a health care delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements mandated in proposed §3.3704. Proposed new §3.3704(f) requires that each insurer monitor compliance with the network adequacy requirements of proposed §3.3703(e) on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. The Department anticipates that proposed §3.3704(e) and §3.3704(f) could result in costs to comply for insurers. The proposed §3.3704(e) network adequacy requirements include: (i) providing a network sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the current utilization of covered health care services within the specified prescribed geographic and projected utilization of covered health care services; (ii) providing an adequate number of preferred providers available and accessible to insureds 24 hours per day and 7 days per week within the insurer's designated service area; (iii) providing sufficient numbers and types of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area; (iv) providing an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area; (v) providing for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable; (vi) providing, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area; (vii) providing for emergency care by preferred providers that is available and accessible 24/7; (viii) providing for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than 30 miles in non-rural areas and 60 miles in rural areas for primary care and general hospital care and 75 miles for specialty care and specialty hospitals; (ix) ensuring that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions; (x) ensuring that routine care is available and accessible from preferred providers within three weeks for medical conditions or within two weeks for behavioral health conditions; and (xi) ensuring that preventive health services are available and accessible from preferred providers within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services and within three months for an adult.

The Department has determined that the total estimated cost for an insurer to comply with both proposed §3.3704(e) and §3.3704(f) could vary based upon the following components: (i) cost of geographic analysis software; (ii) cost of administrative staff to use the software; (iii) cost of staff to conduct the network monitoring and take corrective action; (iv) cost of legal review of new contracts or renewals of existing contracts as needed to comply with proposed §3.3704(e) and §3.3704(f); (v) cost of additional administrative staff; (vi) cost to print new contracts or renewals of existing contracts; and (vii) cost to transmit new contracts or renewals of existing contracts to physicians and providers. The extent to which an insurer will incur such costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and (f) will require additional monitoring and corrective action in excess of the insurer's current practices. The Department anticipates that some insurers' costs will be minimal because compliance with the Insurance Code §1301.005 and §1301.006 already mandates availability of preferred providers and accessibility to health care services. Though the Department has identified factors attributable to the costs of compliance with proposed §3.3704(e) and (f), it is not possible for the Department to

estimate the total amount of cost attributable to compliance with proposed §3.3704(e) and (f) because there are numerous factors affecting such total that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's current service area and the scope of physicians, providers, and health care services available in the network currently used by the insurer.

*(i) Cost of geographic analysis software.* The Department estimates that the cost of geographic analysis software such as GeoAccess or ArcMap for gap analysis of current networks, if necessary for compliance with proposed §3.3704(e) and §3.3704(f) could be mitigated for those insurers who already have an HMO license or a workers' compensation network certification because the requirements are very similar. It is also possible that an insurer already uses such software in evaluating its network and will not incur a cost for a new purchase of the software. According to one insurer that provided information to the Department, the estimated initial cost of procuring GeoAccess software is $15,000 per user, followed by annual fees of $7,000 per user. Therefore, based on the assumption that each insurer will require two GeoAccess software programs to comply with proposed §3.3704(e) and §3.3704(f), the Department estimates a total initial fee could be $30,000, with annual fees of $14,000 thereafter.

*(ii) Cost of administrative staff to use the software.* In addition to the cost for software to perform gap analysis of an insurer's network, the Department estimates that insurers could incur labor costs for administrative staff to use the geographical analysis software and manage the data and reporting functions of the software to comply with proposed §3.3704(e) and §3.3704(f). The Department anticipates that the amount of administrative staff time will range between 10 to 100 hours per month on an ongoing basis. The Department anticipates that approximately 10 to 40 hours will be needed for a small service area, and 40 to 100 hours will be needed for a large service area. The Department received input from one insurer that the hourly wage for software-trained staff is $18.00 to $35.00 per hour. Therefore, an insurer with a small service area could incur costs of $180.00 to $1400, and an insurer with a large service area could incur costs ranging from $720 to $3500 per month on an ongoing basis. The extent to which an insurer will incur such monthly costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and §3.3704(f) will require additional staff work in excess of the insurer's current practices.

*(iii) Cost of staff to conduct the network monitoring and take corrective action.* The Department estimates that insurers could incur costs for monitoring the network adequacy and taking corrective action if needed to comply with proposed §3.3704(e) and §3.3704(f). This cost component identifies the cost of monitoring in addition to that undertaken as part of network gap analysis as identified previously with respect to the cost of compliance with proposed §3.3704(e) and §3.3704(f). For example, this component would include analysis of complaints related to unanticipated balance billing events associated with the reimbursement of health care services furnished at a preferred provider facility by nonpreferred providers. It is anticipated that the monitoring could be conducted by a general operations manager at an estimated salary cost of $1,159.20 to $9,273.60 per month. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. The number of hours spent monitoring the network adequacy will depend on the size and quality of the insurer's current network. It is estimated that monitoring a small service area could require an estimated 20 to 160 hours per month of by a general operations manager. The extent to which an insurer will incur such costs will depend on a number of factors, such as the size and adequacy of the insurer's current network and whether and to what extent compliance with proposed §3.3704(e) and §3.3704(f) will require additional monitoring and corrective action in excess of the insurer's current practices. The Department further anticipates that individual insurers could need to employ a range of 0.5 to 1 additional administrative staffer position if necessary to bring the insurer's current network into compliance with the more specific requirements of proposed §3.3704(e) and (f) by assisting to expand the insurer's network of contracted physicians and providers. The costs to the insurer will vary depending on whether the insurer uses an administrative assistant or a general operations manager, or a combination of both, to assist in contracting with network providers. A general operations manager working for an insurer in Texas earns a median salary of $120,556 per year, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median salary of $43,397 per year, according to the same report. The Department therefore estimates that an insurer could incur the cost of additional administrative staff positions ranging from $21,698.50 to $120,556 per year, depending on the salary level of the staffer and whether the insurer needs the staffer part-time or full-time in order to comply with proposed §3.3704(e) and §3.3704(f). Each insurer, however, has the information necessary to determine its network contracting staff needs to comply with proposed §3.3704(e) and §3.3704(f).

*(iv) Cost of legal staff.* The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding, each new contract or renewal of existing contracts necessary to comply with the network adequacy requirements specified in proposed §3.3704(e). The Department anticipates that most such contracts will likely require little or no modification from the insurer's existing contract templates. Therefore, the legal review service from a lawyer will consist mainly of reviewing new or renewal contracts drafted by the insurer's administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce Commission OES Report. Therefore, the Department estimates that an insurer could incur an average annual cost of less than $51.11 in legal fees on average for each new or renewing contract that requires legal assistance. The cost, however, for a particular insurer could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, and the number of such templates or unique contracts. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost for contracting with an attorney in private practice for the legal review will likely vary from and could exceed the stated salaried hourly wage. Some insurers may require additional direct legal involvement to obtain new contracts or renew existing contracts, including: (i) the negotiation of contract options; and

(ii) the provision of legal advice on the merits and consequences of the addition of contract requirements.

*(v) Cost of additional administrative staff.* The Department anticipates that an insurer will likely require minimal administrative staff time to draft new contracts or amend existing contracts as necessary to ensure compliance with network adequacy requirements as specified in proposed §3.3704(e) and §3.3704(f). This is because the Insurance Code §1301.005 and §1301.006 already respectively require insurers to: (i) ensure that preferred provider benefits are reasonably available to all insureds within a designated service area; and (ii) contract with physicians and providers to ensure that all medical and health care services and items contained in the package of benefits for which is coverage is provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. The Department anticipates that possible drafting as necessary to prepare new contracts as needed to comply with proposed §3.3704(e) and §3.3704(f) could require approximately 0 to 40 hours per month of administrative staff time in addition to the staff hours currently used by the insurer to perform this function. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, review the additional new contracts or renewals of existing contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department, therefore, estimates that the insurer will incur the cost of administrative staff ranging from $0 to $2,318.40 per month, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, review the additional new contracts or renewals of existing contracts.

*(vi) Cost to print new contracts or renewals of existing contracts.* The Department anticipates that an insurer could incur a cost for printing new contracts or renewals of existing contracts to form a health care delivery network that complies with the local market adequacy requirements mandated in proposed §3.3704(e). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper for each new contract or renewal of an existing contract necessary to comply with proposed §3.3704(e). The Department anticipates that the insurer has the information necessary to determine its individual printing costs associated with compliance with proposed §3.3704(e), including the number of pages that will need to be printed per contract, in-house printing costs, or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(vii) Cost to transmit new contracts or renewals of existing contracts.* The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail as necessary to comply with the network adequacy requirements specified in proposed §3.3704(e). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each new contract or renewal of an existing contract that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract. However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or renewals of existing contracts would be incurred by an insurer that opts to transmit new contracts electronically. These costs would be part of the ongoing information technology equipment and service costs of the insurer.

III. Cost to insurers concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations.

*Proposed §3.3705(b)(14): Requirement for network demographics to be included in the written description of policy terms and conditions.* Proposed new §3.3705(b)(14) requires that an insurer offering a preferred provider benefit plan provide information that is updated at least annually regarding the demographics of the insurer's network as part of the written description of the insurer's policy terms and conditions that the insurer must furnish upon request to current and prospective group contract holders and insureds. Section 3.3705(b) provides that an insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all the requirements set forth in the subsection, including the level of disclosure required. Proposed §3.3705(b)(14) requires that the insurer disclose the network demographics for each service area or region, including: (i) the number of insureds in the service area or region; (ii) the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an access plan is in effect for that service area or region and how such access plan may be obtained or viewed, for each provider area of practice including, at a minimum, internal medicine, family/general practice, pediatrics, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery; (iii) the percentage of preferred providers that are accepting new patients by area of practice; (iv) the percentage of providers with board certifications in the area of practice; (v) the number of preferred provider hospitals in the area or region; (vi) the ratio of insureds to hospital beds; (vii) how to view an access plan if one is in effect for the service area or region with respect to hospitals; (viii) the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and (ix) the average surgical site infection rate at each preferred provider hospital in the service area or region. The Department anticipates that compliance with proposed §3.3705(b)(14) could result in costs to comply for insurers. The Department anticipates that the total initial estimated annual cost for an insurer to comply with proposed §3.3705(b)(14) could vary. This estimate is based upon the following components: (i) cost of programming; (ii) cost to print additional pages for written descriptions of terms and policies or handbooks; and (iii) cost of market research analyst staff time to research network demographic information.

*(i) Cost of programming.* The Department anticipates that insurers could incur a one-time cost for programming necessary to summarize network demographics and to automate the inclusion of the network demographic information in the written description of terms and conditions of the insurer's policies or handbook in order to comply with proposed §3.3705(b)(14). The Department estimates that an in-house programmer could require 10 to 25 hours to program a reporting function to monitor

the network demographics of a given service region or area. Based on the Texas Workforce Commission OES Report, computer programmers working for insurers in Texas earn a median hourly wage of $38.51, as indicated at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=15-1021&compare=2. Therefore, the estimated average cost for an insurer's in-house programmer time could range from $385.10 to $962.75 per year, depending upon the number of hours that a particular insurer needs the programmer based upon its unique preferences and existing information technology resources. The Department has in the past received estimates from insurers that indicated that contract programmers could cost $200 per hour or more. An insurer's total cost for programming necessary to generate reports as necessary for compliance with proposed §3.3705(b)(14) will vary depending on the insurer's computer systems and whether the insurer will use an in-house or contract programmer. The actual number of hours, types, and cost of personnel will be determined by each insurer's existing information systems and staffing, and the extent to which each insurer already monitors the network demographics particular to the existing service area or region used in connection with the insurer's preferred provider benefit plans.

*(ii) Cost to print additional pages for written descriptions of terms and policies or handbooks.* The Department anticipates that the insurer will incur a cost for printing reports of network demographics to include in the written description of terms and conditions of the insurer's policies or handbooks in order to comply with the requirements of proposed §3.3705(b)(14). The Department estimates that this cost could be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(iii) Cost of market research staff time to research network demographic information.* The Department anticipates that insurers may need to utilize the services of a market research analyst to research preferred provider demographic information to obtain data for the network demographic reports for the insurer's service area or region in order to comply with proposed §3.3705(b)(14). A market research analyst working for an insurer in Texas earns a median hourly wage of $32.04, according to the Texas Workforce Commission OES Report, available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=19-3021&compare=2. The Department anticipates that one to 10 hours of market research staff time will be needed for this research depending on the insurer's current practices with respect to monitoring the subject network demographic information. The Department therefore estimates that the insurer could incur annual costs to comply with proposed §3.3705(b)(14) ranging from approximately $32 to $320, depending on the total amount of time that the insurer needs the services of the market research analyst and the amount of existing time the insurer allocates to monitoring the specified demographics. There are also two possible factors that may mitigate this cost. Proposed §3.3706(c), relating to credentialing requirements of preferred providers, requires insurers to have a process for selection and retention of preferred providers sufficient to ensure that the providers are adequately credentialed. Insurers will therefore have some of the information necessary for compliance with proposed §3.3705(b)(14) as a result of compliance with proposed new §3.3706(c). Also, costs for those insurers that already monitor some or all of the required demographic information will be mitigated based on the extent of that existing monitoring.

*Proposed §3.3705(e)(2): Requirement for Internet-based notice concerning network adequacy by service area.* Proposed new §3.3705(e)(2) requires insurers that maintain an Internet website for use by prospective consumers or current insureds to provide an online (Internet-based) listing of the state regions, counties or three-digit ZIP Code areas within the insurer's service area that indicates the areas that the insurer has determined meet the required network adequacy requirements and that the insurer has determined do not meet the required network adequacy requirements of this subchapter. The Department anticipates that proposed §3.3705(e)(2) could result in costs to comply for insurers. Though the Department has identified factors attributable to the cost of complying with proposed §3.3705(e)(2), it is not possible for the Department to estimate the total amount of cost attributable to compliance with proposed §3.3705(e)(2) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area(s) and the insurer's current practices for updating its Internet-based website information. The Department anticipates that insurers will primarily incur a cost to comply with proposed §3.3705(e)(2) based upon the cost to publish the required notice on the insurer's established Internet website. The Department estimates that a range of 10 - 25 hours of desktop publisher staff time would be needed initially to prepare and publish the required notice on the insurer's website. A desktop publisher in Texas earns $19.86 per hour according to the Texas Workforce Commission OES Report, as indicated at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=1&indcode=000000&occcode=43-9031&compare=2. Therefore, the cost of a desktop publisher to initially publish the information on the insurer's website would range from $198.60 to $496.50. The Department anticipates that the majority of the work in developing the data that forms the basis of the notice will be available to the insurer as a result of the insurer's ongoing network monitoring activities performed in compliance with proposed §3.3704(e) and §3.3704(f), as previously discussed in the section of the Department's cost analysis entitled "Proposed §3.3704(e) and §3.3704(f): Network adequacy requirements, monitoring, and corrective actions."

The Department anticipates that there will be continuing costs associated with updating the information required to be published for compliance with proposed §3.3705(e)(2), but that the ongoing costs will be less than the costs for the initial reporting. Such updating could require that an insurer incur staff costs for approximately one hour per month as performed by an administrative assistant. An administrative assistant working for an insurer in Texas has a median hourly wage of $20.86 according to the same OES Report. Accordingly, the Department estimates that an ongoing cost of approximately $20.86 per month could be required in updating the insurer's website for compliance with the requirements of proposed §3.3705(e)(2).

*Proposed §3.3705(f): Requirement to give notice of rights under a network plan to insureds.* Proposed new §3.3705(f) specifies that insurers must provide notice of rights under a network plan in all policies, certificates, and outlines of coverage in at least 12 point font. The Department anticipates that proposed §3.3705(f) could result in costs to comply for insurers. The Department an-

ticipates that proposed §3.3705(f) could result in costs to comply for insurers. The Department anticipates that insurers will avoid any mailing costs that would have been be incurred by the insurer as a result of compliance with proposed §3.3705(f) by providing the notice along with the policy at issuance or renewal. Therefore, the Department's estimate of costs for an insurer to comply with §3.3705(f) is based on: (i) the cost of administrative staff to prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage; and (ii) the cost to print additional pages for printed documents.

*(i) Cost of administrative staff to prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage.* The Department anticipates that preparation of the required notice of rights for inclusion in policies, certificates and outlines of coverage as specified in proposed §3.3705(f) will likely require a one-time cost of approximately 2 to 10 hours of administrative staff time. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both positions, perform this function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost of administrative staff ranging from $41.72 to $579.60, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of both positions, prepare the required notice of rights for inclusion in all policies, certificates, and outlines of coverage to comply with proposed §3.3705(f).

*(ii) Cost to print additional pages.* The Department anticipates that an insurer will incur a cost for printing the required notice of rights specified in proposed §3.3705(f) in all policies, certificates, and outlines in order to comply with the requirements of proposed §3.3705(f). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper and that each notice of rights will require approximately one or two printed pages. The Department anticipates that the insurer has the information necessary to determine its individual printing costs necessary for compliance with proposed §3.3705(f), including the number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing. An insurer's costs will also vary based upon the number of policies, certificates, and outlines of coverage for which the insurer must include the notice of rights. The Department anticipates that the total cost to comply with proposed §3.3705(f) could also vary depending on the insurer's administrative processes.

*Proposed §3.3705(h): Requirement to provide a cost-free listing of all preferred providers to insureds at least annually.* Proposed new §3.3705(h) requires insurers to provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers. The Department anticipates that proposed §3.3705(h) could result in costs to comply for insurers. The Department anticipates that the proposed required notice will likely be sent to insureds at the time of policy renewal or issuance in order to avoid additional mailing costs that would otherwise be incurred by the insurer. Therefore, the Department anticipates that the estimated cost for an insurer to comply with §3.3705(f) will depend on cost components including the following: (i) the cost of administrative staff to prepare the required notice of rights; and (ii) the cost to print additional pages.

*(i) Cost of administrative staff to prepare the required notice of rights.* The Department anticipates that preparation of the required annual notice describing how the insured may access a current listing of all preferred providers on a cost-free basis in accordance with proposed §3.3705(h) will likely require a one-time cost of approximately two hours of administrative staff time. The cost to the insurer for staff time associated with preparation of this notice to comply with proposed §3.3705(h) will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both positions, prepare the required notice of rights for distribution on issuance and renewal of policies. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost for administrative staff necessary to prepare the notice specified in proposed §3.3705(h) ranging from $41.72 to $115.92, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two positions, perform the functions necessary to prepare the required notice of rights for distribution.

*(ii) Cost to print additional pages.* The Department anticipates that the insurer will incur an annual cost for printing the required notice describing how the insured may access a current listing of all preferred providers on a cost-free in order to comply with the requirements of proposed §3.3705(f). The Department estimates that this cost will range from approximately $0.06 to $0.08 per page for printing and paper, and that the notice will require less than one page to print. The Department anticipates that the insurer has the information necessary to determine its individual printing costs associated with compliance with proposed §3.3705(h), including the number of pages that need to be printed, in-house printing costs, or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing. An insurer's potential printing costs could also vary based upon the number of policies issued by the insurer.

*Proposed §3.3705(i): Requirement to update preferred provider listings on a quarterly basis.* Proposed new §3.3705(i) requires insurers to update their electronic and nonelectronic preferred provider listings every three months. The Insurance Code §1301.1591(b) currently requires any insurer that opts to maintain an Internet site with listings of preferred providers to update the Internet-based listing quarterly. Therefore, insurers that opt to maintain an Internet-based listing of preferred providers, and that are in compliance with that requirement subject to §1301.1591(b), will not incur any additional costs to comply with proposed new §3.3705(i) with respect to those Internet-based listings. The Department anticipates that proposed §3.3705(i) could result in costs to comply for insurers that do not maintain an updated Internet listing of preferred providers. The Department anticipates that the cost to implement proposed §3.3705(i) is contingent on whether an insurer's directory is made available electronically on the Internet. There is no additional cost anticipated for insurers that currently maintain the online list-

ings pursuant to the Insurance Code §1301.1591(b) in order to comply with proposed §3.3705(i) with respect to the Internet-based listings. Insurers that do not provide Internet-based provider listings and that do not currently update their provider listings more often than quarterly may incur additional cost. The Department anticipates that some insurers will incur a cost to comply with proposed §3.3705(i) based on the cost for staff to update nonelectronic versions of the directory. The Department anticipates that drafting updates to the provider directory will likely require approximately four hours of administrative staff time for those insurers that do not already update their listings at least quarterly. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission OES Report. The Department therefore estimates that an insurer could incur the cost of administrative staff time of 4 hours quarterly, with a total estimated cost of $83.44 per quarter to comply with proposed §3.3705(i). This cost estimate could vary depending on the size of the insurer's network.

*Proposed §3.3705(k): Requirement for insurer to pay a claim for services provided by a nonpreferred provider at the preferred provider rate if an insured reasonably relied on an insurer's preferred provider directory in obtaining the services rendered.* Proposed §3.3705(k) requires that a claim for services rendered by a nonpreferred provider be paid at the applicable preferred benefit coinsurance percentage if an insured demonstrates that: (i) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in a provider listing or provider information on the insurer's website; (ii) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds; (iii) the provider listing or website information was obtained not more than 30 days prior to the date of services; and (iv) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network. Proposed new §3.3705(k) would result in insurers paying increased claim costs if an insured reasonably relies on an inaccurate directory maintained by the insurer. The Department anticipates that insurers could possibly mitigate this potential cost through the addition of provisions in contracts with providers addressing continuity of reimbursement rates to apply for a specified period following termination of a provider's participation in the network in the circumstances described by §3.3705(k). Such a continuity provision could potentially address those instances in which the insured's scheduled appointment or procedure occurs within 30 days of the insured confirming the provider's status as a preferred provider. The Department anticipates that proposed §3.3705(k) could result in a minimal increased cost to an insurer provided that the insurer maintains an up-to-date listing of providers. It is not possible for the Department to estimate the amount of such increase, however, because there are numerous factors involved that are not suitable to reliable quantification, including the frequency of terminations of preferred provider participation rights and contracts, the frequency of insurer updates to its listings of preferred providers, the method employed by the insurer to notify insureds of changes to the preferred provider panel, and the scope of the difference in reimbursement rates for the services provided for a preferred and a nonpreferred provider.

*Proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B): Requirement for insurers to identify in preferred provider listings those hospitals that have agreed contractually to use good faith efforts to accommodate requests from insureds to use preferred providers and to provide information to insureds that support a determination of the status of facility-based physicians or physician groups as preferred or nonpreferred providers.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Proposed §3.3705(l)(1) requires that the provider information include a method for insureds to identify those hospitals that have contractually agreed with the insurer to: (i) exercise good faith efforts to accommodate requests from insureds to utilize preferred providers; and (ii) in those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, provide the insured with information that is furnished at least 24 hours prior to services being rendered, and sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider. The Department anticipates that proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) could result in costs to comply for insurers. The Department anticipates that the total estimated cost for an insurer to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) could vary based upon a number of factors, including the number of network facilities with preferred provider facility-based physicians and cost components including the following: (i) the cost of an initial identification of those hospitals that have contractually agreed to the requirement specified in proposed §3.3705(l)(1) and §3.3705(l)(1)(B) and annual updates of this identification; (ii) the cost of updating changes to the Internet-based preferred provider listings; (iii) the cost of programming or administrative staff hours to implement changes to nonelectronic preferred provider listings; and (iv) additional printing costs for paper (nonelectronic) listings.

*(i) Cost of initial identification of those hospitals that have contractually agreed to the requirements specified in proposed §3.3705(l)(1(A) and§3.3705(l)(1)(B) and annual updates of this identification.* The Department anticipates that an the insurer could incur initial costs to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) for approximately ten hours of staff time and subsequent annual costs of approximately one hour to update the initial identification of those hospitals that have contractually agreed with the insurer to use good faith efforts to accommodate requests from insureds to use preferred providers and to furnish information to insureds related to the status of facility-based physicians as preferred or nonpreferred providers. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs these functions. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur initial costs for administrative staff necessary to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) ranging from $208.60 to $579.60, and subsequent annual costs ranging from $20.86 to $57.96, depending on whether initial determinations and updates to the provider information are performed by an administrative assistant or a general operations manager, or a combination of both positions. The Department anticipates that this cost will vary for each insurer depending on

the size of its network and its administrative systems for tracking such information. The Department further anticipates that each insurer has the information necessary to determine its cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(ii) Cost of annual updating changes to the Internet-based preferred provider listings.* The Department anticipates that each insurer could incur costs ranging from two to five hours of desktop publishing staff time to prepare changes to the Internet-based preferred provider listings that specify the provider information required under proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) and based upon the determinations described in the previous cost component, entitled *"Cost of initial identification of those hospitals that have contractually agreed to the requirements specified in proposed §3.3705(l)(1)(A) and§3.3705(l)(1)(B) and annual updates of this identification."* Based on the Texas Workforce Commission OES Report, a desktop publisher working in Texas earns $19.86 per hour. Therefore, the cost for updating the changes on the insurer's website could range from an annual cost of $39.72 for two hours of time to $99.30 for five hours of time. The Department anticipates that this cost will vary for each insurer depending on the size of its network. The Department further anticipates that each insurer has the information necessary to determine its costs for implementing changes to its Internet-based preferred provider listings based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply. An insurer that does not maintain an Internet-based preferred provider listing will not incur costs for compliance with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) based upon this cost component.

*(iii) Cost of implementing annual changes to nonelectronic preferred provider listings.* The Department anticipates that insurers could incur annual staff costs to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B) associated with implementing changes to nonelectronic preferred provider listings ranging from two to five hours of administrative assistant staff time. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission OES Report. Therefore, an insurer could incur annual costs that range from $41.72 for two hours of staff time to $104.30 for five hours of staff time. The Department anticipates that this cost will vary for each insurer depending on the size of its network. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B).

*(iv) Cost to print additional pages of listings.* The Department anticipates that an insurer could incur an annual cost for printing additional pages in the listings of nonelectronic preferred providers distributed to insureds in order to comply with proposed §3.3705(l)(1)(A) and §3.3705(l)(1)(B). The Department estimates that this cost could range from approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of insureds and number of additional pages to be printed. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed new §3.3705(l)(2): Requirement for insurers to identify in preferred provider listings those hospital locations where more than 10 percent of the dollar amount of claims filed with the insurer by facility-based physicians were not contracted with the insurer.* Under proposed §3.3705(l)(2), the information in an insurer's preferred provider listings must include a method for insureds to identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer, by or on behalf of facility-based physicians, other than neonatologists and pathologists, are filed by or on behalf of a physician that is not under contract with the insurer. The Department anticipates that insurers could incur additional costs as a result of compliance with proposed new §3.3705(l)(2). The Department anticipates that the total estimated annual cost for an insurer to comply with proposed new §3.3705(l)(2) could vary depending on the number of preferred provider hospitals in an insurer's preferred provider network, the insurer's internal administrative systems, and cost components including the following: (i) the cost of programming for necessary reports and updates to Internet-based listings of preferred providers; (ii) the cost of administrative staff hours to assess and monitor the contract and hospital privileges status between facility-based physicians and hospitals; and (iii) the cost to print additional notices in nonelectronic listings of preferred providers.

*(i) Cost of programming to update Internet-based listings of preferred providers.* The Department anticipates that an insurer could incur annual costs to comply with proposed §3.3705(l)(2) based upon programmer staff time necessary to implement changes to the insurer's Internet-based listings of preferred providers for compliance with the requirement specified in proposed §3.3705(l)(2). The Department anticipates that an insurer could require a range of 10 to 100 hours of a programmer's time to perform this function. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department anticipates that the estimated cost to an insurer for programmer staff time would range from $385.10 to $3851, depending upon the amount of time the insurer needs for programming as required for the particular insurer's preferred provider network. The Department has received estimates in the past from insurers indicating that contract programmers could charge as much as $200 per hour. The Department anticipates that this cost for programming to comply with the requirements specified in proposed §3.3705(l)(2) will vary for each insurer depending on how much time is needed for the programming needs of a particular insurer and whether the insurer uses a company staffer or contracts with an outside programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*(ii) Cost of administrative staff hours to assess and monitor the status of contracts and hospital privileges between facility-based physicians and hospitals.* The Department anticipates that if it does not opt to implement this subsection through programming, an insurer could incur a monthly cost for an administrative staffer for 2 to 10 hours to monitor and assess claims from facility-based non-contracted physicians in order to comply with the disclosure requirement specified in proposed §3.3705(l)(2). The monthly costs to an insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to perform this assessment and

monitoring function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur total cost ranging from $41.72 to $579.60 per month depending on whether an administrative assistant or a general operations manager, or a combination of both, performs the assessment and monitoring and how much time is required based upon the particular insurer's preferred provider network. The Department anticipates that this cost will vary for each insurer depending on these factors. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the requirements of proposed §3.3705(l)(2).

*(iii) Cost to print additional notice in nonelectronic listings of preferred providers.* The Department anticipates that an insurer could incur a cost to print additional notices in nonelectronic listings of preferred providers indicating those hospitals at which more than ten percent of claims were from facility-based physicians that are not under contract with the insurer in order to comply with the disclosure requirement specified in proposed §3.3705(l)(2). The Department estimates that this cost could be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that the insurer has the information necessary to determine its individual costs associated with printing the disclosure in nonelectronic preferred provider listings for compliance with proposed §3.3705(l)(2), including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. The Department anticipates that an insurer's printing costs may vary if the insurer elects to use out-of-house printing to comply with the requirements specified in proposed §3.3705(l)(2).

*Proposed §3.3705(l)(4): Requirement for insurers to identify in all preferred provider listings whether each preferred provider is accepting new patients.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Under proposed §3.3705(l)(4), the provider information must indicate whether each preferred provider is accepting new patients. The Department anticipates that proposed §3.3705(l)(4) will not result in a new cost to most insurers because the disclosure is currently required by the Insurance Code §1301.1591 with respect to Internet-based preferred provider listings, and the Department expects that most insurers will be able to print the same information about whether preferred providers are accepting new patients in nonelectronic preferred provider listings as is included in Internet-based listings at minimal cost. Nevertheless, since §1301.1591 does not require such information be provided in listings of preferred providers if the insurer does not maintain an Internet site, proposed new §3.3705(l)(4) could result in new costs to insurers without Internet sites. The Department estimates that the insurer could incur a cost of administrative staff time ranging from two to three hours per month as necessary to compile information provided by providers about whether they are accepting new patients. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs this monitoring function for compliance with the disclosure requirement specified in proposed §3.3705(l)(4). A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur monthly costs to comply with proposed §3.3705(l)(4) for an administrative assistant ranging from $41.72 to $62.58 or the cost of a general operations manager ranging from $115.92 to $173.88. The Department anticipates that this monthly cost will vary for each insurer depending on the size of its network, how many hours are needed to obtain the required information and make the necessary changes to the provider listing, and whether the work is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost for compliance with proposed §3.3705(l)(4) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed §3.3705(l)(5): Requirement that insurers identify in all preferred provider listings those preferred providers who are participating in quality of care regional peer review programs.* Proposed §3.3705(l)(5) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Under proposed §3.3705(l)(5), the provider information must designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program. The Department anticipates that proposed §3.3705(l)(5) could result in costs to comply for insurers. The Department anticipates that the insurer could incur costs associated with identifying which providers are participating in the peer review programs and updating the preferred provider listings with this information. Though the Department has identified the cost factors that follow as attributable to the cost of compliance with proposed §3.3705(l)(5), it is not possible for the Department to estimate the total annual amount of costs attributable to proposed §3.3705(l)(5) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the insurer's internal administrative processes. The Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B) (relating to the optional contract provision regarding notice of non-preferred provider status and of facility ownership interest) could be applicable to estimating the cost for compliance with proposed §3.3705(l)(5) if the insurer elects to comply with proposed §3.3705(l)(5) by means of contract requirements in contracts between the insurer and preferred providers. Because the cost methodology and components are the same if this approach to compliance with the requirements of proposed §3.3705(l)(5) is used by the insurer, the following is a summary of the Department's analysis (which is detailed in this Cost Note under the subheading for "Proposed §3.3703(a)(23)(A) and §3.3703(a)(23)(B)"): (i) cost of less than one hour of administrative staff wages necessary to assist with drafting, updating, and reviewing contracts and amendments, per contract amended; (ii) cost of less than one hour of legal drafting and review of contract terms and representation in contract negotiations in connection with reviewing new or amended contracts, per contract amended; (iii) cost to print new

contracts or amendments to existing contracts; and (iv) cost to transmit new contracts or amendments to existing contracts to physicians and providers by mail or electronically. Additionally or alternatively, the Department anticipates that insurers could incur costs to comply with proposed §3.3705(l)(5) based upon the cost of staff time necessary to identify preferred providers participating in regional peer review programs and make applicable notes in preferred provider listings. The Department anticipates that the total annual costs for each insurer that result from compliance with proposed §3.3705(l)(5) could depend largely on the size of the insurer's network and the insurer's internal business practices, such as the extent that to which the insurer negotiates individual contract terms on a case by case basis. The Department estimates that an insurer could incur a cost for administrative staff time of two to three hours per month to compile information provided by preferred providers about provider participation in peer review programs. The costs to the insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, performs this compilation function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur the monthly cost of administrative staff to perform this compilation and monitoring function to comply with the requirements of proposed §3.3705(l)(5) for an administrative assistant ranging from $41.72 to $62.58 or for a general operations manager ranging from $115.92 to $173.88. The Department anticipates that this monthly cost will vary for each insurer depending on how many hours are needed and whether the work is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost to comply with the requirements of proposed §3.3705(l)(5) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed new §3.3705(l)(6) and §3.3705(l)(7): Requirement to provide disclosures in preferred provider listings directories and the identity of preferred provider facility-based physicians who are able to provide services at preferred provider facilities.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(6), the provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to (i) information about the provider's contract status; and (ii) whether the provider is accepting new patients. Under proposed §3.3705(l)(7), the provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities. The Department anticipates insurers could incur additional costs as a result of proposed new §3.3705(l)(6) and §3.3705(l)(7). The Department has estimated these two sets of anticipated compliance costs as a single cost for the insurer because insurers could potentially comply with them both through a notice to insureds contained in the provider listing. The estimated total cost for an insurer to comply with proposed new §3.3705(l)(6) and §3.3705(l)(7) could vary depending on the insurer's internal procedures. The Department's estimated total annual cost for an insurer to comply with proposed new §3.3705(l)(6) and §3.3705(l)(7) includes the following potential cost components: (i) the cost of administrative staff hours to implement changes to preferred provider listings; and (ii) the cost of responding to additional complaints and inquiries.

*(i) Cost of administrative staff hours to implement changes to preferred provider listings.* The Department anticipates that the insurer could incur a cost for administrative staff for compliance with proposed §3.3705(l)(6) and §3.3705(l)(7) for the cost of one to four staff hours as necessary to implement changes to the insurer's preferred provider listings by amending all listings to include information about: (i) how insureds may notify the insurer about inaccurate listings; and (ii) how insureds may ascertain the information concerning facility-based physicians at preferred provider facilities. The insurer may opt to have an administrative assistant or a general operations manager, or a combination of both, implement the changes to the Internet-based preferred provider listings. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur a one-time cost for administrative staff ranging from $20.86 to $231.84, depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to implement the changes to the listings of preferred providers. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the number of hours that is needed to implement the disclosure requirements of proposed §3.3705(l)(6) and §3.3705(l)(7) and based upon the insurer's existing administrative practices concerning the inclusion of this information in preferred provider listings. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(ii) Cost of handling additional complaints and inquiries.* The Department anticipates that insurers could experience an increase in complaints and inquiries from insureds as a result of compliance with the disclosure requirements of proposed §3.3705(l)(6) and §3.3705(l)(7) because insureds may have better information about how to communicate with the insurer concerning the information included in the insurer's preferred provider listings as a result of the new disclosure requirements. Insurers that do not already provide such disclosures will be required to have staff available to take information about inaccurate preferred provider listings and to provide information about facility-based physicians available to provide services at preferred provider facilities. The Department anticipates that insurers could comply with the requirements specified in proposed §3.3705(l)(6) and §3.3705(l)(7) by using the telephone lines and addresses for correspondence that the insurer presently uses to receive and respond to complaints and inquiries. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the OES Report. The Department anticipates that the number of additional staff hours necessary to comply with §3.3705(l)(6) and §3.3705(l)(7) by responding to inquiries and complaints from insureds could vary based upon the extent to which this information has been previously made available by the insurer to its insureds and the adequacy of the insurer's preferred provider network.

Though the Department has identified factors that may be attributable to the cost of compliance with the disclosure requirements

specified in proposed §3.3705(l)(6) and §3.3705(l)(7), it is not possible for the Department to estimate the total amount of costs attributable to proposed §3.3705(l)(6) and §3.3705(l)(7) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including issues such as the accuracy of the insurers' provider listings, the numbers of insureds, and the numbers of preferred facility-based providers.

*Proposed §3.3705(l)(8): Requirement that provider information must be provided in fonts of not less than 10-point type.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(8) the provider information must be provided in fonts of not less than 10-point type. The Department anticipates that proposed §3.3704(l)(8) could result in costs to comply for insurers. If the carrier currently utilizes a font smaller than 10-point in its provider listing, the Department anticipates that making the necessary changes to a provider listing with noncompliant fonts could require a cost to comply with the requirement specified in proposed §3.3704(l)(8) for a range of 4 to 6 hours of staff time for an administrative assistant if necessary to update the font requirement. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission OES Wage Report. Thus, the Department anticipates that an insurer could incur estimated compliance costs resulting from proposed §3.3704(l)(8) that range between approximately $83.44 and $125.16 as a one-time cost for staff to reformat the insurer's preferred provider listings. The cost to an insurer of compliance with proposed §3.3704(l)(8) could also vary depending on the internal administrative procedures of the insurer and the size of the insurer's preferred provider listing. The Department anticipates that insurers have the information necessary to calculate their costs of compliance with proposed §3.3704(l)(8) as appropriate to the insurer's individual circumstances.

*Proposed §3.3705(l)(9) and §3.3705(l)(10): Requirements that insurers disclose those facilities at which the insurer has no contracts with facility-based physicians and those facilities at which the insurer has a contract with facility-based physician groups which have an exclusive contract with the facility.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(9), the provider information must specifically identify those facilities at which the insurer has no contracts with a particular type of facility-based provider, specifying the applicable provider type. Under proposed §3.3705(l)(10), the provider information must specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type. The Department anticipates insurers could incur additional costs as a result of proposed new §3.3705(l)(9) and §3.3705(l)(10). The Department has addressed the estimated cost to an insurer for compliance with proposed §3.3705(l)(9) and §3.3705(l)(10) jointly because the Department anticipates that insurers are likely to implement the steps necessary to comply with §3.3705(l)(9) and §3.3705(l)(10) in a joint fashion for purposes of efficiency. The Department has determined that the total estimated annual cost for an insurer to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) could range from approximately $334 to $2319. This cost estimate is based upon the following components: (i) the cost of administrative staff as necessary to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10); and (ii) the cost to implement changes to preferred provider listings.

*(i) Cost of administrative staff to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10).* The Department anticipates that an insurer could incur monthly cost for administrative staff as necessary to monitor facilities for the circumstances specified in proposed §3.3705(l)(9) and §3.3705(l)(10): (i) circumstances under which there are facilities for which the insurer has no contracts with a particular type of facility-based provider; and (ii) circumstances under which there are facilities for which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility. Such monitoring of circumstances could require an insurer to incur a cost to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) based upon an estimated one to two hours of staff time per month depending on the procedures developed by the insurer to obtain the information and the number of facilities in the insurer's network. The insurer may opt to have an administrative assistant or a general operations manager, or a combination of both, conduct the monitoring for the existence of these circumstances at facilities. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur costs to comply with proposed §3.3705(l)(9) and §3.3705(l)(10) for the cost of administrative staff ranging from $20.86 to $115.92 per month, depending on whether an administrative assistant or general operations manager, or a combination of both, does the monitoring and whether the monitoring requires one or two hours of staff time. The Department anticipates that this cost will also vary for each insurer depending on the salary level of the staff doing the monitoring and how much time such monitoring requires based upon the unique composition of the insurer's network. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total monthly cost to comply.

*(ii) Cost to implement changes to preferred provider listings.* The Department anticipates that an insurer could incur a cost for administrative staff ranging from one to four hours quarterly to comply with proposed new §3.3705(l)(9) and 3.3705(l)(10) by updating preferred provider listings with new information about the status of facility-based providers at preferred provider facilities. The insurer may opt to have an a general operations manager, or a combination of both, perform this update function. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur a cost to comply with proposed §3.3705(l)(9) and 3.3705(l)(10) for administrative staff ranging from $20.86 to $231.84 per quarter, depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to implement the changes to the provider listings. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the

insurer is aware of that will impact the insurer's total cost to comply.

*Proposed §3.3705(l)(11): Requirement to specify the date on which preferred provider listing information was provided to the insured.* Proposed §3.3705(l) requires an insurer to comply with certain requirements in all preferred provider listings, including any Internet-based postings of information made available by the insurer. Under proposed §3.3705(l)(11), the provider listing must specify the date on which the preferred provider information specified in proposed §3.3705(l) was provided to the insured. The Department anticipates that proposed §3.3705(l)(11) could result in costs to comply for insurers. The Department anticipates that the cost for an insurer to comply with §3.3705(l)(11) could vary depending on whether it already dates its provider listings and the complexity of its Internet-based provider listings and will also depend on the following cost components:

(i) the cost of programming for Internet-based preferred provider listings; and (ii) the cost of administrative staff to implement changes to nonelectronic preferred provider listings.

*(i) Cost of programming for Internet-based preferred provider listings.* The Department anticipates that computer programming time could be needed on a one-time basis for programming Internet-based preferred provider listings to comply with proposed new §3.3705(l)(11). The Department estimates that a programmer could require two to 40 hours to perform the requisite programming. According to the Texas Workforce Commission *OES Report,* computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department anticipates that the estimated cost for programming staff necessary for compliance with proposed §3.3705(l)(11) could range from $77.02 to $1540.40. The Department has received estimates in the past from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed based upon the existing information processing infrastructure in use by each insurer and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the dating requirement specified in proposed §3.3705(l)(11).

*(ii) Cost to implement changes to nonelectronic preferred provider listings.* The Department anticipates that most insurers already date their nonelectronic preferred provider listings and will not incur any cost as a result of §3.3705(l)(11) with respect to the nonelectronic listings. If an insurer does not presently date its nonelectronic preferred provider listings, however, the Department anticipates that an insurer could incur costs for the administrative staff time needed in order to bring the listing into compliance with proposed §3.3705(l)(11). The Department estimates that it would take less than one hour of administrative time to update the date of the preferred provider listing each time the preferred provider listing is updated, which must be at least quarterly pursuant to proposed §3.3705(i). The Department anticipates that an insurer is likely to opt to have either an administrative assistant or general operations manager, or a combination of both, implement the dating requirement as specified in §3.3705(l)(11). A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission *OES Report.* An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur quarterly costs of compliance with proposed §3.3705(l)(11) for administrative staff at or below a range of $20.86 to $57.96 each time a provider listing is updated. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed for implementing the changes and whether performance of this function is done by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost for compliance with proposed §3.3705(l)(11) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*Proposed §3.3705(m): Requirement for insurer to provide notice to each individual and group policy holder that the preferred provider benefit plan relies upon an access plan as specified in proposed §3.3709.* Proposed new §3.3705(m) requires insurers operating a preferred provider benefit plan that relies upon an access plan as specified in proposed §3.3709 to provide notice of this fact to each individual and group policy holder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes made available by the insurer pursuant to §3.3705(e)(2). The Department anticipates that proposed §3.3705(m) could result in costs to comply for insurers. The Department has determined that the total estimated cost for issuance of the notice at policy issuance and at least 30 days prior to renewal of an existing policy as required by §3.3705(m) will vary depending on the adequacy of the insurer's network and the number of policyholders, but will be based on the following cost components: (i) the cost of any programming to automate issuance of the required notices; (ii) the cost of administrative staff to provide the notices, if not automated; and (iii) the cost to print and issue the required notices.

*(i) Cost of programming to automate issuance of the required notices.* The Department anticipates that an insurer could incur costs for reprogramming its computer systems to include the notice of use of an access plan in or with other documents issued at policy issuance and at the time of renewal to comply with proposed new §3.3705(m). According to the Texas Workforce Commission OES Report, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department estimates that a programmer could require from two to 40 hours to do the requisite programming. Therefore, the Department estimates the programming cost incurred by the insurer to comply with proposed §3.3705(m) could range from approximately $77 to $1540.40. The Department has in the past received estimates from insurers indicating that fees for contract programmers could cost as much as $200 per hour or more. The Department further estimates that an insurer's total programming cost to comply with proposed §3.3705(m) will vary depending on the insurer's computer systems, whether the insurer uses a company staff programmer or a contract programmer.

*(ii) Cost of using staff to issue the required notices, if not automated.* The Department anticipates an insurer could alternatively utilize staff services to issue the access plan notices for compliance with proposed §3.3705(m) if issuance is not automated. The Department estimates that one or more hours of

additional administrative staff time could be needed per month to issue the notices manually. The Department anticipates that an insurer would opt to utilize an administrative assistant to perform this notification. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report as indicated in the Texas Workforce Commission OES Report. The Department therefore estimates that an insurer could incur costs for administrative staff time of at least $20.86 to issue the notice manually. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed per month to issue the notices, the number of policyholders, and the internal administrative processes of the insurer. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3705(m).

*(iii) Cost to print and issue the required notices.* The Department anticipates that an insurer could incur costs for printing the notices concerning the use of an access plan as required by §3.3705(m). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of notices needed, in-house printing costs, or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing. The Department does not anticipate that insurers will incur an additional mailing cost for the required notices, because the notices may be issued in or with other documents at the time of policy issuance or renewal. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*Proposed §3.3705(n): Requirement for insurers to provide notice of contract termination and the resulting substantial decrease in availability of preferred facility-based physicians.* Under proposed §3.3705(n)(1), an insurer is required to provide notice of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility. "Substantial decrease" is defined in the proposed rule to occur when (i) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or (ii) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination. However, under proposed §3.3705(n)(2), no notice is required if alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in proposed §3.3705(n)(1) are made available to insureds at the facility such that the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease. Proposed §3.3705(n)(3) requires an insurer to prominently post notice of §3.3705(n)(1) termination and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds. Proposed §3.3705(n)(4) requires that the notice of the termination and of the decrease in availability of providers must be maintained on the insurer's website for six months from the initial posting or until adequate preferred providers of the same specialty become available to insureds at the facility.

Proposed §3.3705(n)(5) requires an insurer to update its Internet-based preferred provider listing in accordance with certain specified time periods. The Department anticipates that proposed §3.3705(n) could result in costs to comply for insurers based upon the following components: (i) the cost of administrative staff to monitor for applicable notices of terminations; and (ii) the cost of programming to post and remove notices on an insurer's website.

*(i) Cost of administrative staff to monitor for applicable notices of terminations.* The Department anticipates that administrative staff time could be needed by an insurer to monitor monthly changes in preferred facility-based physicians as provided to the insurer by contracted facilities pursuant to proposed §3.3703(26)(A). The Department estimates that one hour of administrative time could be needed monthly for this monitoring. The Department anticipates that an insurer is likely to opt to have either an administrative assistant or general operations manager, or a combination of both, conduct such monitoring. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur costs for administrative staff time ranging from $20.86 to $57.96 per month. The Department anticipates that this monthly cost will vary for each insurer depending on how many hours are needed for monitoring and whether the monitoring is conducted by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total monthly cost to comply with proposed §3.3705(n).

*(ii) Cost of programming to post and remove notices from an insurer's website.* The Department anticipates that computer programming time will be needed to post and remove notices from the insurer's website to comply with proposed new §3.3705(n). The Department anticipates that a programmer would require approximately half an hour per month to post and remove these notices. Based on the Texas Workforce Commission OES Report, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that the cost for programmer time will be $19.26 per month to comply with proposed §3.3705(n). In addition to the Department's determination of the cost estimate for this component, the Department received from one insurer a cost estimate of $100,000 for programming plus an additional annual expense of $100,000. However, the insurer provided no basis or methodology for this estimate. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the actual amount of time that is needed by the insurer and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*Proposed §3.3705(o): Requirement for insurers to make disclosures in all insurance policies, certificates, and outlines of cover-*

*age concerning the reimbursement of basic benefit services from nonpreferred providers.* Under proposed §3.3705(o), an insurer is required to make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services in accordance with the specifications in the proposed rule. Proposed §3.3705(o) requires that insurers must disclose how reimbursement of nonpreferred providers will be determined. If reimbursement is based upon data concerning usual, customary, or reasonable provider charges, the insurer must disclose: (i) the source of the data; (ii) how the data is used to determine reimbursements; and (iii) the existence of any applicable reductions. If reimbursement is based upon any amount other than full billed charges, the insurer must: (i) disclose that the insurer's reimbursement may be less than the billed charge; (ii) disclose that the insured may be liable to the nonpreferred provider for balance bill amounts; (iii) provide a description of the methodology used to determine the reimbursement amount; and (iv) provide a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service. The Department anticipates that proposed §3.3705(o) could result in costs to comply for insurers. The Department has determined that the cost for an insurer to comply with proposed §3.3705(o) will vary dependent on a number of factors, including the number of insureds, and will also be dependent on the following components: (i) the cost of drafting disclosures; (ii) the cost of printing additional pages for printed documents; (iii) the cost of filing fees for approval of new policies, certificates, and outlines of coverage information; and (iv) the cost of mailing new policies, certificates, and outlines of coverage or endorsements thereof containing the required notices to the Department for approval.

*(i) Cost of drafting disclosures.* The Department anticipates that insurers will require staff time to draft, on a one-time basis, disclosures as required by proposed new §3.3705(o). The Department estimates that an insurer's staff would require two to ten hours to draft the required disclosures. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same. Therefore, the Department's estimated cost for the staff time required to comply with proposed §3.3705(o) ranges from $41.72 to $579.60. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the amount of time that is needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3705(o).

*(ii) Cost to print additional pages.* The Department anticipates that the insurer could incur a cost for printing additional pages as necessary to include disclosures in all policies, certificates, and outlines of coverage to comply with the requirements of proposed new §3.3705(o). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of disclosures, number of insureds and number of additional pages to be printed. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly printing cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3705(o), including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(iii) Cost of filing fees for approval of new policy, certificate and outline of coverage information.* To comply with proposed §3.3705(o), insurers will need to file for Department approval, on a one-time basis, new policies, certificates and outlines of coverage or endorsements thereof containing the required notices. The Department estimates that the insurer will incur a cost of $100 per form filed with the Department. The cost, however, will vary depending on the number of forms filed by each insurer. The Department anticipates that each insurer has the information necessary to determine its estimated total cost for policy fees required in connection with compliance with proposed §3.3705(o).

*(iv) Cost of mailing new policies, certificates and outlines of coverage or endorsements thereof containing the required disclosures to the Department for approval.* The Department anticipates that the insurer could incur a cost for mailing new policies, certificates and outlines of coverage or endorsements to the Department for approval, as required for compliance with proposed §3.3705(o). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each new policy, certificate and outline of coverage or endorsement thereof containing the required disclosures that do not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per disclosure mailed to the Department. The Department anticipates that the total cost will vary for each insurer depending on the number of disclosures, number of additional pages to be mailed, and the business practices of the insurer. The Department anticipates that each insurer has the information necessary to determine its estimated total cost for mailing new policies, certificates and outlines of coverage or endorsements to the Department for approval.

*Proposed §3.3705(p): Requirement for plan designations.* Proposed new §3.3705(p) requires that any plan that uses a preferred provider service delivery network that does not comply with proposed network adequacy requirements for hospitals disclose: (i) on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network plan documents; and (ii) on the cover page of any nonelectronic provider listing describing the network that the plan has a "Limited Hospital Care Network". The Department anticipates that proposed §3.3705(p) could result in costs to comply for insurers.

The Department has determined that the total estimated cost for an insurer to comply with §3.3705(p) will vary based on how often the insurer's designation changes and the number of insureds and will also depend on the cost of drafting designations for use in policy documents.

The Department anticipates that insurers will require staff time to make amendments to insurance documents and preferred provider listings as provided in proposed §3.3705(p) each time the status of the network changes. The Department estimates that an insurer's staff would require one to two hours to make

the required clerical changes. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. Therefore, the estimated cost for the staff time an insurer could require ranges from $20.86 to $115.92. The Department anticipates that an insurer's total cost will vary for each insurer depending upon the amount of time that is needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total cost to prepare documents that comply with proposed §3.3705(p) based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply. The Department anticipates that an insurer will file this information with the Department when it files the its forms pursuant to implementation of §3.3705(o).

*Proposed §3.3705(q): Loss of Status as an Approved Hospital Care Network.* Proposed new §3.3705(q) specifies that if a preferred provider benefit plan designated as an Approved Hospital Care Network (AHCN) under proposed §3.3705(p) no longer complies with the network adequacy requirements for hospitals under proposed §3.3704 and does not correct such non-compliance within 30 days, the insurer is required to: (i) notify the Department in writing of its change in status, (ii) cease marketing as an AHCN; (iii) and inform insureds of the change at the time of renewal. The Department anticipates that proposed §3.3705(q) could result in costs to comply for insurers. The Department has determined that the total cost for an insurer to comply with §3.3705(q) could vary depending on a number of factors, such as how often the insurer's designation changes and the number of insureds, and will also be based upon the following components: (i) the cost to print notices for insureds; (ii) the cost to notify the Department in writing; and (iii) the cost of administrative staff to monitor, prepare, and transmit the required notices to insureds.

*(i) Cost to print notices for insureds.* The Department anticipates that an insurer could incur a cost for printing notices for insureds at the time of renewal to comply with proposed new §3.3705(q). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. The Department anticipates that this cost will vary for each insurer depending on the number of insureds and the number of required notices. The Department further anticipates that each insurer has the information necessary to determine its estimated total printing cost based on this factor and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3709(q). The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(ii) Cost to notify the Department.* The Department anticipates that the insurer could incur a cost for notifying the Department, as required for compliance with proposed §3.3705(q), including mailing notices to the indicated address. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard 5 digit zip code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each notice that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per notice mailed to the Department. The Department anticipates that each notice will be no more than one page and that the total cost will vary for each insurer depending on how often such notices will have to be filed with the Department.

*(iii) Cost to monitor, prepare, and transmit the required notices to insureds.* The Department anticipates that an insurer could incur a monthly cost for an administrative staffer for one to three hours per month: (a) to monitor and assess whether its preferred provider benefit plan designated as an Approved Hospital Care Network (AHCN) under proposed §3.3705(q) complies with the network adequacy requirements for hospitals under proposed §3.3704; and (b) to prepare and add the required notices to the renewal documents that are being sent to the insured. The monthly costs to an insurer will vary depending on whether an administrative assistant or a general operations manager, or a combination of both, is used to perform the requisite functions. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur total cost ranging from $20.86 to $173.88 per month depending on whether an administrative assistant or a general operations manager, or a combination of both, performs the requisite functions. The Department anticipates that this cost will vary for each insurer depending on how many hours are needed to monitor changes; how many insureds must receive the required notice; and the amount of time that it takes to prepare and include the required notices in an insured's renewal documents. The Department further anticipates that each insurer has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with the requirements of proposed §3.3705(q).

IV. Cost to insurers concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process.

*Proposed §3.3706(a)(5): Prohibition against avoiding high risk populations when selecting participating preferred providers.* Under proposed §3.3706(a)(5), selection standards used by insurers in choosing participating preferred providers must not directly or indirectly: (i) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or (ii) exclude a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization. The Department has determined that the cost for insurers to comply with proposed §3.3706(a)(5) will be contingent on the adequacy of the insurer's network, the size of the service area, and whether the insurer's current practices would violate the proposed prohibition in particular parts of the state. The Department does not anticipate any additional costs and requested input from insurers and other stakeholders on

any additional costs they anticipate would result from complying with proposed new §3.3706(a)(5). The Department did not receive any input. The Department anticipates that any cost to comply with proposed §3.3706(a)(5) will be minimal because any impact in requiring additional contracts with providers in high risk areas may be offset by the lower contract rates that may be obtained when more providers are contracted in the service area. It is not possible for the Department to provide any precise estimate for such minimal cost because the factors involved, such as physician and provider fees and insurer reimbursement rates, vary widely and are not suitable to reliable quantification.

*Proposed §3.3706(c): Requirement to have a documented process for selection and retention of preferred providers that are adequately credentialed.* Under proposed §3.3706(c), an insurer is required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. Proposed new §3.3706(c) requires that, at a minimum, an insurer's credentialing standards are required to meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC. The Department anticipates that an insurer could incur costs associated with selecting and retaining adequately credentialed preferred providers. Any additional cost that could be incurred will depend on the insurer's current credentialing standards. If an insurer is currently following the standards promulgated by the NCQA or URAC, the Department anticipates that there should be no additional cost for compliance. The Department has determined that, if an insurer's current standards are not compliant with proposed §3.3706(c), any cost for complying will depend on several factors, including the size of the insurer, the insurer's service area, the size of the insurer's network, the type of provider being credentialed, the cost of accessing databases used in credentialing, and whether the insurer handles its own credentialing or if the insurer delegates its credentialing to a credentialing service. The Department asked insurers for input on whether their standards are compliant with proposed §3.3706(c), and if they are presently credentialing providers. The Department did not receive any input indicating that there would be an increased cost resulting from proposed §3.3706(c). The Department, however, anticipates that proposed §3.3706(c) could result in costs to comply for insurers.

The Department anticipates that an insurer may incur costs for time spent researching credentials and for fees for accessing credentialing databases as a result of compliance with proposed §3.3706(c). The Department has determined that an insurer may spend up to one hour per provider researching physician and provider credentials with an additional estimated access cost of $10.00 per physician to access the various credentialing databases. The Department anticipates that an insurer may opt to have an administrative assistant perform these tasks. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the Texas Workforce Commission OES Report. Therefore, the Department estimates that an insurer could incur administrative staff costs of approximately $30.86 per provider in verifying credentials. as a result of compliance with proposed §3.3706(c). The Department anticipates that this monthly cost component will vary for each insurer depending on how many providers are researched for credentialing. The Department further anticipates that each insurer has the information necessary to determine its approximate estimated cost to comply with proposed §3.3706(c).

V. Cost to insurers concerning waiver requirements due to failure to contract in local markets.

*Proposed §3.3707(b): Waiver of network adequacy standards due to failure to contract in local markets.* Under proposed §3.3707(a), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the insurer may seek a waiver from one or more network adequacy requirements. Proposed new §3.3707(b) requires an insurer seeking a waiver to file the request with the Department and submit a copy of the request to any physician or provider named in the waiver at the same time that the request is filed with the Department. The insurer may use any reasonable means to submit the copy of the request to any provider or physician named in the request and is required to maintain proof of the submission. The Department anticipates that proposed §3.3707(b) could result in costs to comply for insurers. The Department has determined that the total estimated cost for an insurer to comply with §3.3707(b) will vary depending on factors such as which local markets are included in the insurer's service area, the availability of physicians and providers in that service area, and the negotiating positions of the insurer and the available physicians and providers. The cost to comply with proposed §3.3707(b) could also vary according to the following cost components: (i) the cost to draft the waiver request; and (ii) the cost of sending the waiver to the Department and any physician or provider named in the request.

*(i) Cost to draft waiver requests.* The Department anticipates that an insurer could incur a cost for administrative staff as necessary to draft waiver requests to comply with proposed §3.3707(b). The Department has determined that an insurer may require from two to four hours to handle the tasks involved in drafting each specific waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff cost as a result of compliance with proposed §3.3707(b) ranging from $41.72 to $231.84 for each waiver requested. The Department anticipates that this cost will vary for each insurer depending on the number of waiver requests that must be drafted and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing the waiver request to comply with proposed §3.37907(b)

*(ii) Cost to transmit waiver requests by mail to the Department and any physician or provider named in the waiver requests.* The Department anticipates that an insurer could incur a cost to transmit waiver requests to the Department, physicians, and providers as required in proposed §3.3707. The Department anticipates that an insurer could incur a cost for printing each page of the waiver request. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per enve-

lope for the $0.26 cost; this cost estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit the requisite waiver requests by mail in accordance with the requirements of proposed §3.3707(b) will vary depending on the total number of waiver requests, the number of physicians and providers named in the request, and the business practices of the insurer. Further, insurers may opt to use less expensive alternatives than mail for transmission of waiver requests to physicians and providers as permitted under §3.3707(b).

*Proposed §3.3707(e): Requirement to apply for renewal of a waiver request annually.* Under proposed §3.3707(e), an insurer is required to apply annually for renewal of a waiver that is granted by the Department pursuant to proposed §3.3707(e), and the insurer must submit the request for waiver at the same time that the insurer files the annual network adequacy report required under proposed §3.3709. The Department anticipates that insurers could incur costs to comply with proposed §3.3707(e). The Department has determined that the total estimated cost for an insurer to comply with proposed §3.3707(e) could vary depending on the factors relevant to the decision to file the initial request for a waiver pursuant to proposed §3.3707(d). The cost could also vary according to the following cost components: (i) the cost to draft the waiver renewal request; and (ii) the cost of sending the waiver renewal request to the Department and any physician or provider named in the request.

*(i) Cost to draft waiver renewal requests.* The Department anticipates that an insurer could incur a cost for administrative staff to draft waiver renewal requests. as necessary to comply with proposed §3.3707(e). The Department has determined that an insurer may require as much as one hour per specific waiver request per year to handle the tasks involved in drafting the waiver renewal request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur staff costs to comply with proposed §3.3707(e) of up to $57.96 per waiver renewal. The Department anticipates that this annual cost will vary for each insurer depending on the number of waiver renewal requests that must be drafted and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing them.

*(ii) Cost to transmit waiver renewal requests by mail to the Department.* The Department anticipates that an insurer will incur a cost if the insurer sends the Department the waiver renewal request to comply with the requirements of proposed §3.3707(e). The Department estimates that this cost could be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver renewal request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per mailing. However, the total cost to the insurer to transmit the requisite waiver renewal requests by mail to comply with proposed §3.3707(e) will vary depending on the total number of waiver renewal requests, the manner of transmission of the requests to physicians and providers, the number of physicians and providers names in the renewal requests, and the business practices of the insurer.

VI. Cost to insurers for payment of nonpreferred provider claims; related disclosures and waivers.

*Proposed §3.3708: Requirements for reimbursements for nonpreferred provider claims when no preferred provider is reasonably available, requirements concerning methodologies used to determine reimbursement of nonpreferred providers generally, and required disclosures.* Under proposed §3.3708(a), an insurer must comply with the proposed §3.3708(b) requirements when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances requiring emergency care and other certain specified circumstances. Under proposed §3.3708(b), when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured, the insurer is required to: (i) pay such claim at the preferred benefit coinsurance level; and (ii) credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. Under proposed §3.3708(c), an insurer is required to calculate reimbursements of all nonpreferred providers for services that are covered under the health insurance policy pursuant to an appropriate methodology. Under proposed §3.3708(c)(1), insurers that base reimbursements upon usual, reasonable, or customary charges are required to use a methodology that is based on the generally accepted industry standards and practices for determining the customary billed charge for a service that fairly and accurately reflects market rates, including geographic differences in costs. Alternatively, under proposed §3.3708(c)(2), insurers that base reimbursements on claims data are required to use a methodology that is based upon sufficient data to constitute a representative and statistically valid sample. Proposed §3.3708(c)(3) requires that either reimbursement methodology used by an insurer must be updated no less that once per year. Proposed §3.3708(c)(4) prohibits the insurer from using data that is more than three years old. Proposed §3.3708(c)(5) requires that the insurer's methodology must be consistent with nationally recognized and generally accepted bundling edits and logic. Proposed §3.3708(d) requires that an insurer pay all covered services at least at the plan's basic level of coverage, regardless of where the services are provided. Proposed §3.3708(e) requires that when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available, the insurer is required to include a notice with each explanation of benefits that the insured has a right to request the following information for comparison purposes: (1) the median per-service amount the insurer has negotiated with preferred providers for the service

furnished; (2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers; and (3) the amount that would be paid under Medicare for the service. Proposed §3.3708(f) provides a method for an insurer to apply for a six-month waiver of the requirements of §3.3708(e). The Department anticipates that proposed §3.3708 could result in costs for insurers. The Department anticipates that the insurer could incur cost in complying with proposed new §3.3708(b), relating to reimbursement of nonpreferred provider claims when no preferred provider is reasonably available, and in complying with proposed new §3.3708(c), relating to the utilization of the required methodologies to determine reimbursements of all nonpreferred providers. The cost could be based upon the following components: (i) the cost of programming the insurer's computer system to pay claims as required under proposed §3.3708(b); (ii) the cost of implementing any required changes to reimbursement methodologies and updating methodologies as required; (iii) the cost of additional credit for insureds' deductibles for out-of-pocket amounts, if applicable; (iv) the cost of acquisition of additional data concerning usual, reasonable, or customary charges if necessary; (v) the cost of acquisition of additional claims data if necessary; (vi) the cost of additional reimbursement amounts, if applicable, resulting from the update of reimbursement methodologies; (vii) the cost of paying for all covered services at least at the plan's basic level of coverage, regardless of where the services are provided; (viii) the cost of including a notice with each explanation of benefits relating to services rendered by a nonpreferred provider of the insured's right to request information for comparison purposes; (ix) the cost of providing information on request regarding reimbursement rates pursuant to other methodologies; and (x) the cost to apply for a temporary waiver of the requirements in proposed §3.3708(e).

*(i) Cost of programming the insurer's computer system to pay claims as required under proposed §3.3708(b).* The Department anticipates that an insurer's cost for programming its computer system to comply with the requirement of proposed §3.3708(b) will depend on the computer system used by each particular insurer. The Department anticipates that there could be a one-time programming cost for an insurer to program its computer systems to pay the specified claims of nonpreferred providers at the preferred benefit coinsurance level and credit out-of-pocket amounts toward the insured's deductible and annual out-of-pocket maximum. The Department anticipates that the number of required programming hours necessary to comply with proposed §3.3708(b) range from 10 hours for minimal programming to 100 hours for complex programming. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that an insurer's cost for computer programming time necessary to comply with proposed §3.3708(b) could range from approximately $385.10 to $3851.00. Additionally, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the cost of programming a computer system to pay claims as required by proposed §3.3708(b) will vary based on several factors, including the complexity of the insurer's current computer system, whether the insurer employs in-house programmers or contract programmers, and the number of hours needed to program the computer system.

*(ii) Cost of implementing any required changes to reimbursement methodologies and updating methodologies as required.* The Department anticipates that insurers could incur one-time initial costs in changing claims payment systems to comply with the methodological requirements in proposed §3.3708(c) if the insurer's reimbursements do not already conform to the requirements of the proposed rule. The Department estimates that these costs could include one to 300 hours of staff time to make any necessary changes to the insurer's reimbursement methodologies to conform to the requirements of §3.3708(c). The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur staff costs to comply with proposed §3.3708(b) that range from $20.86 to $17,388 for revision of the insurer's payment methodologies. The Department anticipates that this one-time cost will vary for each insurer depending on the insurer's current reimbursement methodologies and whether the insurer opts to have an administrative assistant or general operations manager, or a combination of both, perform the tasks involved in preparing them. An insurer's costs of compliance with §3.3708(c) could also include programming costs for an insurer to program its computer systems to process specified nonpreferred provider claims and to automate updating functions in accordance with any changes in reimbursement methodologies. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 200 hours to address complex programming needs. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department has received estimates from insurers in the past indicating that the cost of contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract programmer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost to implement changes to its reimbursement methodologies based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

*(iii) Cost of additional credit for insured's out-of-pocket amounts, if applicable.* The Department anticipates that the cost of compliance with the requirement in proposed §3.3708(b)(2) that insurers credit to the insured's deductible and annual out-of-pocket maximum any out-of-pocket amounts actually paid to nonpreferred providers in cases where a preferred provider was not reasonably available will depend on: (a) the adequacy of the insurer's network; (b) the incidence of balance billing by nonpreferred providers; (c) and payment of balance billed amounts by insureds; (d) the method used by the insured to submit claims; (e) the procedure used by the insurer to accept claims; and (f) the procedure used by the insurer to credit the out-of-pocket amounts appropriately. The Department anticipates that an in-

surer's primary cost of compliance will be staff time to receive and verify evidence of out-of-pocket payments by insureds and credit such amounts to insureds' deductibles and annual out-of-pocket maximum in the insurer's data systems. The Department has previously attempted to study the incidence of balance billing but has been unable to estimate its frequency. This is discussed in the Department's report entitled Report of the Health Network Adequacy Advisory Committee, at page 15, January 2009, available at http://www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc. Therefore, the Department is unable to provide a reliable estimate for an insurer's compliance with this requirement.

*(iv) Cost of acquisition of additional data concerning usual, reasonable, or customary charges if necessary.* The Department anticipates that some insurers in order to comply with proposed new §3.3708(c)(1) may incur annual costs to acquire additional data for determining usual, reasonable, or customary charges in accordance with proposed §3.3708(c). The Department anticipates that the total amount of this cost will depend on several factors, including the insurer's current reimbursement methodologies, the size of the insurer, the service areas the data will be required to cover, and other facts specific to each insurer. The Department further anticipates that each insurer either has the information necessary or has access to the information necessary to determine its estimated cost to acquire data concerning usual, reasonable, or customary charges based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

*(v) Cost of the acquisition of additional claims data, if necessary.* The Department anticipates that the cost to insurers to comply with proposed new §3.3708(c)(2) through the use of claims data will be negligible for insurers already utilizing such data. Insurers that base reimbursements on claims data prospectively may incur initial one-time costs to adapt their computer systems to acquire such internal claims data. The Department anticipates that the total amount of this initial one-time cost will depend on several factors, including the insurer's current reimbursement methodologies, the size of the insurer, and the format of the insurer's current claims data. These costs could include programming costs for insurers to program their computer systems to comply with the requirements relating to the utilization of updated claims data as specified in proposed §3.3708(c). Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department has received estimates in the past from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the number of hours required for such programming will likely vary considerably for each insurer depending on the factors noted herein. The Department anticipates that each insurer either has the information necessary or has access to the information to determine its estimated total one-time cost to acquire additional claims data based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

*(vi) Cost of additional reimbursement amounts, if applicable, resulting from the update of reimbursement methodologies.* The Department anticipates that some insurers may incur additional claims costs to comply with proposed new §3.3708(c) due to revisions to their reimbursement methodologies. For example, the requirement to update data no less than once per year and not the prohibition against the use of data more than three years old might result in higher average claims data, potentially resulting in higher reimbursements of nonpreferred providers. The amount of the increase in reimbursements will depend on factors unique to each insurer, such as the data the insurer currently utilizes. Similarly, reimbursement rates could rise if the insurer's current reimbursement methodologies have not been based on generally accepted practices as required in proposed §3.3708(c)(1); have not fairly and accurately reflected market rates, including geographic differences in costs, as required in proposed §3.3708(c)(1); have not been based on sufficient data to constitute a representative and statistically valid sample, as required in proposed §3.3708(c)(2); have included data that is more than three years old, as prohibited in proposed §3.3708(c)(4); or have not been consistent with nationally recognized and generally accepted bundling edits and logic as required in proposed §3.3708(c)(5). The Department anticipates that each insurer has the information necessary or has access to the information to determine its estimated total costs for increased reimbursement based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply with proposed §3.3708(c).

*(vii) Cost of paying for all covered services at least at the plan's basic level of coverage, regardless of where the services are provided.* The Department does not anticipate that there will be a cost to insurers for implementation of §3.3708(d), which requires that carriers pay all covered basic benefits at least at the basic level of coverage for all covered services, regardless of where the services are provided. It is the Department's understanding that this is the current practice of insurers. However, if it was not the current practice of an insurer, the Department anticipates that each insurer would have the information necessary to determine its estimated total costs resulting from its implementation of proposed §3.3708(d), based on factors such as the size of the carrier, the current incidence of claims denied on this basis, and the dollar amount of claims denied on this basis.

*(viii) Cost of including a notice with each explanation of benefits relating to services rendered by a nonpreferred provider of the insured's right to request information for comparison purposes.* The Department anticipates that some insurers could incur costs in complying with proposed new §3.3708(e), which requires that, when services are rendered to an insured by a nonpreferred provider because a preferred provider is not reasonably available, the insurer is required to include a notice on each explanation of benefits that the insured has a right to request information as specified in proposed §3.3708(e) for comparison purposes. Insurers could incur costs for costs to their computer systems to provide this notice with appropriate explanations of benefits to insureds when claims are adjudicated. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 100 hours to address complex programming needs. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost insurers as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract pro-

grammer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(ix) Cost of providing information on request regarding reimbursement rates pursuant to other methodologies.* The Department anticipates that some insurers could incur costs in complying with proposed new §3.3708(e) when insureds make requests for the listed information about reimbursement amounts determined under different methodologies, including: (1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished; (2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic benefits provided by nonpreferred providers; and (3) the amount that would be paid under Medicare for the service. Pursuant to §3.3708(e), insurers could incur cost in developing programming to provide, on request, the specified information. The Department anticipates that the number of hours required for such programming could range from 10 hours to address minimal programming needs to 300 hours to address complex programming needs. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total programming costs will vary for each insurer depending upon several factors, including the complexity of the insurer's current computer systems, whether the insurer opts to have a company computer programmer or a contract programmer perform the requisite programming, and the number of hours needed. The Department further anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(x) Cost to apply for a temporary waiver of proposed §3.3708(e).* The Department anticipates that some insurers could incur cost in complying with proposed new §3.3708(f) in applying for a temporary waiver of the requirement to include a notice with each explanation of benefits that the insured has the right to request specified comparison data when services are rendered to the insured by a nonpreferred provider because no preferred provider is reasonably available to the insured. The Department anticipates that an insurer could incur a cost to comply with proposed §3.3709(f) for administrative staff to draft the waiver request. The Department has determined that an insurer may require from two to five hours to handle the tasks involved in drafting the waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff costs ranging from $41.72 to $289.80 to submit the waiver request. The insurer could also incur a cost to transmit the waiver request. The Department anticipates that an insurer could incur a cost for printing each page of the waiver request as a result of compliance with proposed §3.3708(f). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request transmitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit by mail the requisite waiver requests in accordance with proposed §3.3708(f) could vary for each insurer.

VII. Cost to insurers for annual network adequacy and access plan reports.

*Proposed §3.3709(a) - (e): Requirement to file a network adequacy report and local market access plan, if applicable, with the Department annually before April 1 and prior to marketing any plan in a new service area.* Proposed new §3.3709(a) requires an insurer to file an annual network adequacy report with the Department on or before April 1st of each year and prior to marketing any plan in a new service area. Proposed new §3.3709(b) and (c) specify the content required for inclusion in the annual report. Proposed new §3.3709(d) requires an insurer to submit a local market access plan if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements in §3.3704. Proposed new §3.3709(e) specifies the required content of the access plan. The Department anticipates that proposed §3.3709(a) - (d) could result in costs to comply for insurers. The Department anticipates that the insurer could incur costs associated with the requirement to file a network adequacy report and to file a local market access plan, as part of that report, if applicable. The Department anticipates that an insurer may incur a cost to comply with proposed §3.3709(a) - (d) based upon the following components: (i) the cost of administrative staff to draft the annual adequacy report, including network data and the access plan; (ii) the cost of programming for necessary reports and increased requirements for complaint tracking; and (iii) the cost of implementation of procedures to assist insureds to obtain services when no preferred provider is reasonably available.

*(i) Cost of administrative staff to draft the annual network adequacy report, including local market access plan.* The Department anticipates that an insurer could incur cost for drafting of the annual report to comply with proposed new §3.3709 and any local market access plan to comply with proposed new §3.3709. The Department anticipates that an insurer is likely to opt to have either an administrative assistant or a general operations manager, or a combination of both, draft the requisite reports. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department anticipates that it could take from approximately 10 to 15 hours annually to draft the required annual report and an additional 20 to 40 hours annu-

ally to draft any required local market access plan. The Department therefore estimates that an insurer could incur the cost of administrative staff ranging from $625.80 to $3187.80 per year. The Department anticipates that this annual cost will vary for each insurer depending on the size of the insurer's service area, the adequacy of its network, the number of specific inadequacies identified in its network, and whether the tasks are performed by an administrative assistant or a general operations manager, or a combination of both. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost to comply with proposed §3.3709 based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*(ii) Cost of programming for necessary reports and increased requirements for complaint tracking.* The Department anticipates that an insurer could incur a one-time cost for programming its systems to be able to produce required data pursuant to §3.3709 to be included in annual network adequacy and any necessary local market access plan reports. According to the Texas Workforce Commission OES Report, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department anticipates that a programmer could require from 10 to 100 hours for the requisite programming. The Department therefore estimates that the programming cost could range from $385.10 to $3851.00. In addition to the Department's determination of cost estimates for this component, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total one-time cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*(iii) Cost of implementing of procedures to assist insureds to obtain services when no preferred provider is reasonably available.* The Department anticipates that an insurer could incur an additional cost in implementing procedures to assist insureds in obtaining services when no preferred provider is reasonably available, as required by §3.3709(e). The cost of implementing such procedures will depend on a number of factors, including the adequacy of the insurer's provider network, the size of the insurer, and its internal processes. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed §3.3709(f)(1)(A): Requirement to establish and implement documented procedures to identify requests for preauthorization of services for insureds that require services of physicians or providers not contracted with the insurer.* Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(1)(A), an insurer must utilize a documented procedure to identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer. The Department anticipates that proposed new §3.3709(f)(1)(A) could result in costs to comply for insurers. The Department anticipates that an insurer could incur an initial one-time programming cost associated with establishing and implementing procedures to identify preauthorization requests from insureds for use in all service areas for which a §3.3709(d) local market access plan is submitted.

*Cost of programming to identify insured's preauthorization requests.* The Department anticipates that an insurer could incur costs for a computer programmer to program a system to identify preauthorization requests from insureds to comply with proposed new §3.3709(f)(1)(A). Based on the Texas Workforce Commission OES Report, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. The Department estimates that a programmer could require from five to fifty hours to perform the requisite programming. Therefore, the Department estimates that the cost for such programming could range from $192.55 to $1925.50. In addition to the Department's determination of cost estimates for this component, the Department has received estimates from insurers in the past indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's total cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed and whether the insurer uses a company staff programmer or a contract programmer. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed §3.3709(f)(1)(B): Requirement to establish and implement a documented procedure to furnish insureds a pre-service estimate of the amount the insurer will pay the nonpreferred physician or provider; and to notify the insured of potential liability to physician or provider for additional amounts.* Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Proposed §3.3709(f)(1)(B) requires an insurer to establish and implement documented procedures for use in all service areas for which a local market access plan is submitted to furnish insureds an estimate of the amount the insurer will pay the nonpreferred physician or provider prior to rendition of health care services.

The Department anticipates that proposed §3.3709(f)(1)(B) could result in a one-time cost to an insurer to program its computer systems to derive an estimate of payment amounts. The Insurance Code §1456.007 currently requires that an insurer provide, within 10 days of a request, an estimate of what it will pay for services rendered by an out-of-network provider. Section 3.3709(f) requires that for services that are the subject of an access plan, the insurer must be able to provide such information prior to services being rendered. The Department anticipates that the number of programming hours to comply with proposed §3.3709(f)(1)(B) may range from 10 hours for minimal programming to 100 hours for complex programming. Based on the Texas Workforce Commission OES Report, computer programmers working for insurers Texas earn a median hourly wage of $38.51. Therefore, the Department estimates that the cost for computer programming time could range from approximately $385.10 to $3851. Additionally, the Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that costs will vary depending on the insurer's current compliance with

the Insurance Code §1456.007, the complexity of the insurer's current computer systems, whether the insurer uses a company staff computer programmer or a contract programmer and the number of hours needed for the requisite computer programming. The Department further anticipates that each insurer has the information necessary to determine its estimated cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3709(f)(1)(B).

*Proposed §3.3709(f)(2): Requirement to utilize a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level.* Under proposed §3.3709(f), an insurer is required to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(2)(A), an insurer is required to utilize a documented procedure to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured. Under proposed §3.3709(f)(2)(B), an insurer is required to utilize a documented procedure to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. The Department anticipates that proposed new §3.3709(f)(2) could result in costs to comply for insurers. The anticipated costs for complying with proposed §3.3709(f)(2) are based on the cost of programming to supplement an access plan.

*Cost of programming to supplement an access plan.* The Department anticipates that an insurer could incur an initial one-time cost for programming needed to identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured and make initial and, if required, subsequent payment to such claims at the preferred benefit coinsurance level, to comply with §3.3709(f)(2). The Department estimates that a programmer would require 10 to 100 hours to program the database to generate the correct payment to nonpreferred providers. Based on the Texas Workforce Commission OES Report, computer programmers working for insurance carriers in Texas earn a median hourly wage of $38.51. Therefore, the estimated one-time cost for a programmer's time would range from $385.10 to $3851.00. In addition to the Department's determination of cost estimates for this component, the Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that an insurer's initial one-time cost for the requisite programming will vary for each insurer depending upon the number of hours of programming that is needed, whether the insurer uses a company staff programmer or a contract programmer, and how the insurer currently complies with the Insurance Code §1301.005, which requires insurers to reimburse nonpreferred providers at the same percentage level of preferred providers if services are not available through a preferred provicer in the service area. The Department further anticipates that each insurer has the information necessary to determine its estimated total annual cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total annual cost to comply.

*Proposed §3.3709(i): Requirement to establish an access plan within 30 days of the date on which the network becomes noncompliant with the network adequacy requirements specified in §3.3704.* Under proposed §3.3709(i), if the status of a preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the plan no longer complies with the network adequacy requirements specified in §3.3704 for a specific service area, the insurer is required to establish an access plan within 30 days of the date on which the network becomes non-compliant. The Department anticipates that only a few insurers will be required to comply with proposed §3.3709(i) because only those insurers that are in violation of the §3.3704 network adequacy standards for a specific service area will be required to establish an interim access plan. The Department assumes that most if not all insurers will comply with the rule. However, for any insurer that is required to comply with proposed §3.3709(i), the Department has determined that the same methodology and cost components used to estimate the compliance costs for insurers to comply with proposed §3.3709(d) (relating to the requirement to file a local market access plan with the Department annually) could be applicable to estimating the cost for compliance with proposed §3.3709(i) if the insurer's preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the insurer is required to establish an access plan. Specifically, the Department's cost analysis of §3.3709(d) (which is detailed in this Cost Note under the subheading for "Proposed §3.3709(a) and §3.3709(d)") in terms of administrative staff to draft access plan, would also be applicable to §3.3709(i). Interim access plans required under §3.3709(i) are only required to be filed with the Department upon request.

VIII. Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements

*Proposed §3.3713(a), (b), and (d): Requirement to electronically submit to the Department information concerning the effects of uncompensated care.* Under proposed §3.3713(a), effective seven years from the effective date of proposed §3.3713, an insurer is required to submit to the Department on the first business day of each July information concerning the effects of uncompensated care including: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. Under proposed §3.3713(b), the information concerning the effects of uncompensated care are required to be submitted to the Department electronically in a format acceptable to the Department, and the acceptable formats include Microsoft Word and Excel documents. Under proposed §3.3713(d), an insurer is required to include in facility contracts provisions permitting the insurer to obtain the information necessary to complete the required financial analysis. While full implementation of proposed §3.3713(a), (b), and (d) is required as of seven years from the effective date of the section, the Department anticipates that insurers could begin to incur compliance costs within the first five years of the effective date.

The Department anticipates that an insurer could incur cost in complying with proposed §3.3713(a), (b), and (d). The estimated cost is based upon the following cost components: (i) programming to compile data to reflect the uncompensated care costs of contracted preferred provider facilities; (ii) staff time to begin preparations to draft required documents; and (iii) amendment of facility contracts to facilitate obtaining required data.

*(i) Cost of programming to compile data to reflect the uncompensated care costs of contracted preferred provider facilities.* The Department anticipates that insurers may incur an initial one-time cost for programming in order to comply with proposed new

§3.3713(a). These costs could include programming costs for insurers to program their computer systems to compile the data received from contracted preferred provider facilities regarding their uncompensated care costs. Based on the Texas Workforce Commission OES Report, computer programmers working for an insurer in Texas earn a median hourly wage of $38.51. Also, an insurer may opt to employ a contract programmer for such programming. The Department in the past has received estimates from insurers indicating that contract programmers could cost as much as $200 per hour or more. The Department anticipates that the number of hours required for such programming will likely vary for each insurer depending on the number of contracted preferred provider facilities, the insurer's current computer systems, whether the insurer gradually implements the requirement for its contracted preferred providers to report uncompensated care costs, and the extent to which the insurer already monitors uncompensated care costs of contracted preferred providers. The Department anticipates that each insurer has the information necessary to determine its estimated total one-time cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(ii) Cost of staff time to begin preparations to draft required documents.* The Department anticipates that insurers may incur staff costs in preparing to draft the documents that will be required in years seven and beyond after the effective date of the rule. The Department anticipates that an insurer is likely to opt to have both an administrative assistant and a general operations manager work on the necessary preparations. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department anticipates that it could take up to 10 hours annually for both the administrative assistant and the manager to do the necessary preparatory work. The Department therefore estimates that an insurer could incur the cost of administrative staff of approximately $579.60 per year for a general operations manager and $208.60 per year for an administrative assistant for a total of approximately $788 per year. The number of hours will likely vary for each insurer depending on the number of contracted facilities and how the insurer chooses to implement the requirements. The Department anticipates that each insurer has the information necessary to determine its estimated cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's total cost to comply.

*(iii) Cost of amending facility contracts to mandate that facilities provide required information.* The Department estimates that the total cost for an insurer to include the contract provisions required pursuant to §3.3713(d) may involve the following components, which are discussed in greater detail in the following cost analysis: (a) cost of less than one hour of administrative staff wages necessary to assist with drafting, updating, and reviewing contracts and amendments, per contract amended; (b) cost of less than one hour of legal drafting and review of contract terms and representation in contract negotiations in connection with reviewing new or amended contracts, per contract amended; (c) cost to print new contracts or amendments to existing contracts; and (d) cost to transmit new contracts or amendments to existing contracts to physicians and providers by mail or electronically. These costs may additionally vary as a result of pass-through costs from facilities.

*(a) Cost of administrative staff wages for drafting and basic review related to contracts.* The Department anticipates that an insurer's administrative staff will do most if not all of the drafting and basic review of new contracts or amendments to existing contracts. The Department anticipates that this drafting will likely require on average less than one hour of administrative staff time per contract modified. The cost to an insurer may vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, review the new or amended contracts. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that an insurer could incur an average annual cost of staff wages for drafting and basic review of contracts of less than $57.96 per contract, with variation anticipated depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, draft and review the new or amended contract language templates. The cost could also vary depending upon whether the contracting practices of an insurer require review of multiple or single contract templates, the extent to which contracts vary, and, if multiple contract templates or unique contracts are used, the number of such templates or unique contracts.

*(b) Cost of legal staff.* The Department estimates that an insurer could incur an average annual cost of less than one hour of legal service from a lawyer in connection with drafting, reviewing, and representing the insurer in contract negotiations regarding each new contract or amendment of existing contracts that includes the provisions specified in proposed §3.3713(d). The Department anticipates that the legal review service from a lawyer will consist mainly of reviewing new or amended contracts drafted by the insurer's administrative staff. The median hourly wage for a lawyer performing work in the insurance and related industries in Texas is $51.11 according to information available from the Texas Workforce OES Report. Therefore, the Department estimates that an insurer might incur an average annual cost of less than $51.11 in legal costs on average for each new or amended contract reviewed. The cost could vary depending upon whether the insurer employs or contracts with a lawyer for performance of the legal services, whether the contracting practices of the insurer require review of multiple or single contract templates, the extent to which contracts vary, whether multiple contract templates or unique contracts are used, the number of such templates or unique contracts, and the insurer's position in contract negotiations. If additional hours of legal representation are required in connection with contract negotiations, this cost for legal services will be accordingly higher. The Department also anticipates that the cost for contracting with an attorney in private practice for the legal review will likely vary from and might exceed the stated salaried hourly wage.

*(c) Cost to print new contracts or amendments.* The Department anticipates that an insurer could incur cost for printing new contracts or amendments to existing contracts in order to include contract requirements in facility contracts as specified in proposed §3.3713(d). The Department estimates that there will likely be approximately one page per contract and that the cost would be approximately $0.06 to $0.08 per page for printing and paper; the total cost will depend on the total number of pages and on the number of contracts the insurer chooses to amend. The Department anticipates that the insurer has the information

necessary to determine its individual cost, including number of pages that will need to be printed, and in-house printing costs or out-of-house printing costs. An insurer's potential printing costs may vary if the insurer does not use in-house printing.

*(d) Cost to transmit new contracts or amendments.*The Department anticipates that an insurer could incur a cost if the insurer opts to transmit new contracts or amendments to existing contracts by mail to include the contract provisions in facility contracts as specified in proposed §3.3713(d). According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each contract or amendment of existing contracts that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28 per contract or per set of amendments of existing contracts. However, the total cost to the insurer to transmit contracts by mail will vary depending on the number of pages, number of contracts or amendments, whether this cost is in addition to or subsumed in the cost of mailing contracts with new language pursuant to other portions of this proposed rule, and the business practices of the insurer. The Department estimates that no new cost for the transmission of new contracts or amendments to existing contracts would be incurred by an insurer that opts to transmit new contracts or amendments electronically. These costs would simply be part of the ongoing information technology equipment and service costs of the insurer.

Though the Department has identified factors attributable to the cost of implementing proposed new §3.3713(d), it is not possible for the Department to estimate the total amount of cost attributable to proposed new §3.3713(d) because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the size of the insurer's service area and the number of existing preferred provider contracts.

*Proposed §3.3713(c): Requirement to make the information concerning the effects of uncompensated care as reported to the Department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage.* Under proposed §3.3713(c), effective eight years from the effective date of proposed §3.3713, an insurer is required to make the information concerning the effects of uncompensated care as reported to the Department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage, concerning the effects of uncompensated care including (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. While full implementation of proposed §3.3713(c) is required as of eight years from the effective date of the section, the Department anticipates that insurers could begin to incur compliance costs within the first five years of the effective date.

The Department anticipates that an insurer could incur costs associated with making the required information concerning the effects of uncompensated care as reported to the Department publicly available and providing such notice in all policies, certificates, and outlines of coverage. The Department anticipates that, because the proposed required notices will likely be sent to insureds at the time of policy renewal or issuance, no additional mailing costs will be incurred by the insurer. Therefore, the estimated cost for an insurer to comply with §3.3713(c) will depend on the cost of (i) administrative staff to prepare and include the required notice in all policies, certificates, and outlines; (ii) printing of notice of availability to be included in each policy, certificate, and outline of coverage; (iii) filing fees for Department approval of new policy, certificate and outline of coverage information; and (iv) printing and transmitting of the new policy, certificate and outline of coverage documents by mail to the Department.

*(i) Cost of administrative staff to include the required notice in all policies, certificates, and outlines.* The Department anticipates that preparing the required information concerning the effects of uncompensated care for public availability and providing such notice in all policies, certificates, and outlines of coverage as required in proposed §3.3713(c) will likely require a one-time cost of approximately 2 to 10 hours of administrative staff time. The cost to the insurer will vary depending on whether the insurer elects to have an administrative assistant or a general operations manager, or a combination of both, prepare the required notice and include the notice in all policies, certificates, and outlines. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur the one-time cost of administrative staff ranging from $41.72 to $579.60, depending on whether the insurer has an administrative assistant or a general operations manager, or a combination of the two, to prepare the required information and include the required notice in all policies, certificates, and outlines.

*(ii) Cost to print required notice of availability.* The Department anticipates that the insurer will incur a cost for printing the required notice of the availability of the information concerning the effects of uncompensated care to be included in all policies, certificates, and outlines in order to comply with the requirements of proposed §3.3713(c). The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper, and that the notice will take less than one page to print. The Department anticipates that the insurer has the information necessary to determine its individual cost, including number of pages that will need to be printed, in-house printing costs, or out-of-house printing costs.

*(iii) Cost of filing fees for approval of new policy, certificate and outline of coverage information.* To comply with proposed §3.3713(c), insurers may need to file for Department approval, on a one-time basis, new policies, certificates and outlines of coverage, or endorsements thereto containing the required notice. The Department estimates that the insurer could incur a cost of $100 per form filed with the Department. The cost, however, will vary depending on the number of forms filed by each insurer and whether the form is already being submitted to the Department due to other requirements of this proposed. The Department anticipates that each insurer has the information necessary to determine its estimated total cost to comply.

*(iv) Cost to print and transmit new policy, certificate and outline of coverage documents by mail to the Department.* The Depart-

ment anticipates that the insurer will incur a cost if an insurer opts to transmit the amended documents to the Department by mail. The Department anticipates that an insurer could incur a cost for printing each page. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each amended document that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per document. However, the total cost to the insurer to transmit by mail the requisite documents in accordance with proposed §3.3713(c) will vary depending on the total number of documents amended, total number of pages printed and mailed, whether document amendments relating to multiple requirements of this proposed rule could be filed in a single mailing, and the business practices of the insurer.

*Proposed §3.3713(e): Waiver from some or all of the §3.3713 requirements relating to the submission and disclosure of information concerning the effects of uncompensated care.* Under proposed §3.3707(e), an insurer may apply for a six-month waiver from some or all of the §3.3713 requirements regarding uncompensated care costs of contracted preferred providers by submitting to the Department, as specified under proposed §3.3713(e)(1), a waiver application on 8 1/2 by 11 inch paper that is legible, in typewritten, computer-generated, or printer's proof format; and signed by an officer of the insurer. Proposed §3.3713(e)(2), specifies the Department address to which the waiver application must be mailed. Under proposed §3.3713(e)(3), an application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including: (i) undue hardship, including financial or operational hardship; (ii) the geographical area in which the insurer operates; (iii) total number of insureds covered by the insurer and the number of insureds impacted by the waiver; (iv) specification of the insurer's plan to achieve compliance with the §3.3713(a) - (d) requirements, including identification of actions already taken and those planned to be taken; and (v) the estimated cost of compliance with §3.3713(a) - (d) and an estimate of the increased cost for compliance at an earlier date. The Department anticipates that submission of the waiver application contemplated by proposed §3.3713(e) could result in costs to comply for insurers.

The Department has determined that an insurer that opts to apply for a §3.3713(e) waiver could incur costs to prepare and submit the waiver. The Department's estimate is based upon the following cost components: (i) drafting of the waiver request; and (ii) mailing the waiver request to the Department

*(i) Cost to draft the waiver request.* The Department anticipates that an insurer could incur a one-time cost for administrative staff to draft the waiver request to comply with proposed §3.3713(e). The Department has determined that an insurer may require from four to six hours of staff time to handle the tasks involved in drafting the waiver request, including obtaining the necessary information and writing the request. The Department anticipates that an insurer may opt to have an administrative assistant or general operations manager, or a combination of both, perform these tasks. A general operations manager working for an insurer in Texas earns a median hourly wage of $57.96, according to the Texas Workforce Commission OES Report. An administrative assistant working for an insurer in Texas earns a median hourly wage of $20.86 according to the same report. The Department therefore estimates that the insurer could incur staff cost ranging from $83.44 to $347.76 in preparation of the waiver request. The Department anticipates that this cost will vary for each insurer depending on the complexity of the waiver request that must be drafted and whether the insurer opts to have an administrative assistant or general operations manager perform the tasks involved in preparing the waiver request. The Department further anticipates that each insurer has the information necessary to determine its estimated cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3713(e).

*(ii) Cost to mail waiver request to the Department.* The Department anticipates that an insurer that elects to file a waiver request could incur a cost to mail the waiver request to the Department as required by proposed §3.3713(e)(2. The Department estimates that this cost will be approximately $0.06 to $0.08 per page for printing and paper. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has further determined that the cost of a standard business envelope is $0.016. Accordingly, for each waiver request submitted that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per request. However, the total cost to the insurer to transmit by mail the requisite waiver requests in accordance with proposed §3.3713(e)(2) will vary depending on the complexity of the waiver request and the business practices of the insurer. The Department anticipates that each insurer has the information necessary to determine its estimated mailing cost based on these factors and any other factors that the insurer is aware of that will impact the insurer's cost to comply with proposed §3.3713(e)(2).

The Department does not anticipate any additional cost to persons required to comply with the proposed amendments and new sections of this proposal. Any other costs to such persons for each year of the first five years the proposed amendments and new sections will be in effect are the result of existing statutory requirements and regulations and not the result of the adoption, enforcement, or administration of the proposed amendments and new sections.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small or micro businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit; is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1)

defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.001(1) does not specify a maximum level of gross receipts for a "micro business." The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

Analysis of Economic Impact

In accordance with the Government Code §2006.002(c), the Department has determined that the proposed amended sections if adopted might have an adverse economic effect on approximately five health plan issuers that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that would be required to comply with the proposed new sections and amendments. The estimated number of small and micro businesses is based on an analysis of the results of a survey of insurers with preferred provider health benefit plan products on file with the Department. In that survey, five health plan issuers indicated that they qualify as small businesses.

The Department has identified eight sets of requirements that may result in compliance costs to small and micro-business insurers. These costs will result only to those small and micro-business insurers that offer preferred provider benefit plans in Texas. These sets of requirements are: (i) proposed §3.3703 concerning contract requirements; (ii) proposed §3.3704 concerning network adequacy requirements and insureds' freedom of choice; (iii) proposed §3.3705 concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations; (iv) proposed §3.3706 concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process; (v) proposed §3.3707 concerning waiver requirements due to failure to contract in local markets; (vi) proposed §3.3708 concerning payment of certain basic benefit claims and related disclosures and waivers; (vii) proposed §3.3709 concerning the annual network adequacy and access plan reports; and (viii) proposed §3.3713 requiring submission and disclosure of information concerning the effect of uncompensated care and waiver to that requirement. These costs are more fully discussed in the Public Benefit/Cost Note part of this proposal, as is the potential use of a PPO network as an alternative means to achieve compliance.

Regulatory Flexibility Analysis

Section 2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis ". . . consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

I. Cost to insurers concerning contract requirements. *Proposed §3.3703(a)(23) and §3.3703(a)(24): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred providers and of ownership interest in the facility to which the insured is being referred.*

Proposed new §3.3703(a)(23)(A) and (B) specify that a contract between an insurer and a non-institutional preferred provider may contain, at the insurer's option, provisions requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or provider has an ownership interest in the facility to which the insured is being referred. Proposed new §3.3703(a)(24) specifies that contractual provisions permitted in new §3.3703(a)(23)(A) and (B) must allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers. The cost of compliance with proposed new §3.3703(a)(23)(A) and (B) will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though proposed new §3.3703(a)(23)(A) and (B) may have an adverse economic effect on small or micro businesses that elect to include new permitted contractual terms, the Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code because small or micro businesses are not required by statute or by this proposed rule to make any contractual changes as a result of proposed §3.3703(a)(23)(A) and (B). Therefore, those small and micro businesses that modify their preferred provider contracts to include the new permitted provisions do so at their own choice, and as a result they agree to bear the additional costs required for compliance with proposed new §3.3703(a)(23)(A) and (B). The limitations on such optional contractual provisions stated in new §3.3703(a)(24) reflect the current statutory prohibition in the Insurance Code §1301.067 that prohibits insurers from interfering with the relationship between the patient and their physician, and the current requirements in the Insurance Code §1301.005 and §1301.006, that require all covered health care services be made available and accessible. In accordance with the Government Code §2006.002(c-1), the Department has determined that §3.3703(a)(24) does not require a regulatory flexibility analysis because the proposed provision reflects current statutory provisions and provides exceptions to the use of newly permitted optional contractual provisions. Therefore, the small or micro-business insurer will not incur any costs for compliance that they do not opt to incur.

*Proposed §3.3703(a)(25): Contract provisions between an insurer and a preferred provider that mandate that a preferred provider comply with all applicable requirements of the Insurance Code §1661.005.* Proposed §3.3703(a)(25) specifies that a contract between an insurer and preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005, relating to refunds of overpayments from enrollees. (Note: Some statutory provisions referenced in this proposal use the term "enrollees" and some use the term "insureds"; but the Department interprets these two terms to have the same meaning for purposes of this proposal.) The Insurance Code §1661.005, effective May 30, 2009, mandates that a physician, hospital, or other health care provider that receives an overpayment from an enrollee refund such overpayment within 30 days of the date the determination an overpay-

ment was made. Proposed new §3.3703(a)(25) mandates that this statutory requirement be included in any contract between an insurer and a preferred provider. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the proposed new §3.3703(a)(25) may have an adverse economic effect on small or micro businesses, it is neither legal nor feasible to waive the provisions of the subsection for small or micro businesses. It is the Department's position that to waive or modify the requirements of the subsection for small or micro businesses could be interpreted as permitting providers to violate the statutory requirement of the Insurance Code §1661.005 to return overpayments timely. Further, the Department does not directly regulate providers or their billing practices and thus has no direct authority to enforce the requirements of §1661.005 absent a contractual requirement that the Department may require an insurer to enforce. Only by requiring all provider contracts to contain this prohibition, regardless of the size of the insurer, will the Department be able to enforce the requirements of §1661.005 and protect the economic welfare of insureds. Nevertheless, the Department considered exempting small and micro businesses from this requirement, but concluded that this would lead to confusion on the part of providers, who in virtually every case will also be contracted with insurers that do not qualify as small or micro businesses, and will be required by their contracts with those insurers to comply with the Insurance Code §1661.005. Further, without the requisite contractual requirement that all insurers, regardless of size, return overpayments to their insureds, those insureds who have coverage through small or micro-business insurers would not be able to request the assistance of their insurer in seeking return of the overpayment through enforcement of the contractual provision. Therefore, the Department has determined, in accordance with §2006.002(c-1) of the Government Code, that there are no regulatory alternatives to new §3.3703(a)(25) that would meet the objectives of the law and this regulation and be consistent with the health and economic welfare of the state.

*Proposed §3.3703(a)(23)(A) and (B): Optional contract provisions specifying that non-institutional providers must give insureds notice concerning referrals to non-preferred providers and of ownership interests in facilities to which the insured is being referred.* Proposed new §3.3703(a)(23)(A) and (B) specify that a contract between an insurer and a non-institutional preferred provider may contain provisions at the insurer's option requiring a referring physician, provider, or designee to disclose: (i) that the physician, provider or facility to whom the insured is being referred is not a preferred provider; and (ii) whether the referring physician or provider has an ownership interest in the facility to which the insured is being referred. The Department anticipates that proposed §3.3703(a)(23)(A) and (B) could result in costs to comply for small and micro-business insurers. The cost of compliance with these provisions will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

As required by §2006.002(c-1) of the Government Code, the Department considered alternatives to proposed §3.3703(a)(26) that would minimize adverse impact on small or micro businesses. For example, the Department considered exempting small and micro-business insurers from one or more of the provisions of proposed §3.3703(a)(23)(A) and (B) altogether and considered modifying the contract requirements for small and micro-business insurers, but concluded that such alternatives would not adequately achieve the purpose of the proposed rule to provide important information to consumers and thereby protect all insureds in Texas regardless of the size of their insurer. Additionally, exempting small and micro-business insurers from proposed §3.3703(a)(23)(A) and (B) would limit the insurers' ability to comply with the requirement in proposed §3.3705(n) that the insurer notify insureds of a substantial decrease in the availability of preferred facility-based physicians at preferred provider facilities. This would likely result in insureds of small and micro-business insurers being balance billed by new facility based physician groups without adequate notice to the insured and without recourse by the insured based on any lack of notice. Similarly, exempting small and micro-business insurers from proposed §3.3703(a)(23)(A) and (B) could limit their insureds from being able to obtain information about facility-based physicians' typical billed charges. It would also limit the Department's ability to obtain comprehensive information about facility-based physician fees. The Department also considered modifying the requirements of proposed §3.3703(a)(23)(A) and (B) in the case of small and micro-business insurers. For instance, the Department considered extending the period of time for facilities to provide insurers notice of the departure of a facility-based physician group. However, the Department determined that this would reduce the protections to insureds of small and micro-business insurers with no significant financial savings to the small or micro-business insurers in terms of contracting costs. Similarly, permitting facility-based physicians to disclose less information about their billed charges in the context of a small or micro-business insurer or provide less information to the Department in response to surveys would significantly limit public access to billing information with little or no cost savings to small or micro-business insurers.

II. Cost to insurers concerning network adequacy requirements.

*Proposed §3.3704(e) and (f): Network adequacy requirements, monitoring, and corrective actions.* Proposed new §3.3704(e) requires that each preferred provider benefit plan include a health care delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements mandated in proposed §3.3704. Proposed new §3.3704(f) requires that each insurer monitor compliance with the network adequacy requirements of proposed §3.3703(e) on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. The Department anticipates that proposed §3.3704(e) and (f) could result in costs to insurers to comply. The cost of compliance with the proposal will not vary between large insurers and small or micro-business insurers, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to the proposed §3.3704(e) and (f) that would minimize adverse impact on small or micro-business insurers. For example, the Department considered exempting small and micro-business insurers from one or more of the provisions of proposed §3.3704(e) and (f) altogether and considered modifying the network requirements for small and micro-business insurers, but concluded that

such alternatives would not adequately achieve the purpose of the proposed rule to ensure, pursuant to the Insurance Code §1301.005 and §1301.006, that all insureds in Texas have reasonable access to preferred provider benefits and that adequate contracted personnel, specialty care, and facilities are available and accessible to all such insureds. Exempting small and micro businesses from the network requirements in proposed §3.3704(e) or even reducing the network requirements for those insurers within their service areas could result in additional costs and potentially less access to care for insureds of small or micro-business insurers. Consumers are generally unable to shop for health insurance on the basis of the adequacy of a network, both because they generally do not know what types of care they will require in the future and because it is difficult to recognize when there are gaps in the adequacy of a network. Section 1301.006 of the Insurance Code requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. The intent of this statutory requirement is that consumers can expect that an adequate network will be provided, regardless of the size of the insurer. Further, if a small or micro-business insurer is unable to contract for an adequate network, there are alternatives under the proposed rule that enable such an insurer to apply for a waiver of network requirements or file an access plan to ensure that care will be available. Additionally, pursuant to proposed §3.3704(g), a small or micro-business insurer will be able to elect to operate in a limited service area, thus limiting the amount of contracting that will be necessary for compliance, and thereby exempt itself to some extent from network adequacy requirements. For these reasons, the Department has determined, in accordance with the Government Code §2001.006(c-1), that there are no alternative methods of accomplishing the objective of network adequacy for all insureds in Texas, regardless of the size of the insurer, while minimizing any adverse economic impact on small or micro businesses.

III. Cost to insurers concerning the nature of communication with insureds, readability, mandatory disclosure requirements, and plan designations.

*Proposed §3.3705(b)(14), (e)(2), (f), (h), (i), (k), (l)(1), (l)(2), (l)(4) - (l)(11), and (m) - (q).* Proposed amendments to §3.3705 impose a number of new requirements on insurers relating to mandated communications with the public. Proposed §3.3705(b)(14) requires that an insurer offering a preferred provider benefit plan provide information that is updated at least annually regarding the demographics of the insurer's network as part of the written description of the insurer's policy terms and conditions that the insurer must furnish upon request to current and prospective group contract holders and insureds. Proposed new §3.3705(e)(2) requires insurers that maintain an Internet website for use by prospective consumers or current insureds to provide an online (Internet-based) listing of state regions, counties or three-digit ZIP Code areas within the insurer's service area that indicates the areas that the insurer has determined that meet and that do not meet the network adequacy requirements. Proposed new §3.3705(f) specifies that insurers must provide a notice of rights under a network plan in all policies, certificates, and outlines of coverage in at least 12 point font. Proposed new §3.3705(h) requires insurers to provide notice to insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. Proposed new §3.3705(i) requires insurers to update their electronic and non-electronic preferred provider listings every three months. Proposed new §3.3705(k) requires insurers pay out of network claims at the preferred coinsurance level if an insured reasonably relies on an inaccurate listing maintained by the insurer. Proposed new §3.3705(l)(1) requires insurers to provide a method for insureds to identify those hospitals that have contractually agreed with the insurer to exercise good faith efforts to accommodate requests from insureds to utilize preferred providers and to provide information to insureds that support a determination of the status of facility-based physicians or physician groups as preferred or nonpreferred providers. Proposed new §3.3705(l)(2) specifies that in all preferred provider listings, the insurer must include a method for insureds to identify those hospitals at which more than ten percent of the dollar amount of total claims filed with the insurer were by or on behalf of physicians not under contract with the insurer. Proposed §3.3705(l)(4) requires an insurer to indicate whether each preferred provider is accepting new patients in all preferred provider listings, including any Internet-based postings of preferred provider information made available by the insurer for use by insureds. Proposed new §3.3705(l)(5) requires insurers to provide notice in all preferred provider listings of those preferred providers that have notified the insurer of participation in a regional quality of care peer review program. Proposed new §3.3705(l)(6) specifies that an insurer is required to provide a method by which insureds may notify the insurer of inaccurate information in the preferred provider directory. Proposed new §3.3705(l)(7) requires an insurer's preferred provider directory contain information on how insureds can identify facility-based physicians that are able to provide services at preferred provider facilities. Proposed §3.3705(l)(8) requires that in all preferred provider listings, including any Internet-based postings of information made available by the insurer, the provider information must be provided in fonts of not less than 10-point type. Proposed new §3.3705(l)(9) requires an insurer's preferred provider listing specifically identify those facilities at which the insurer has no contracts with the applicable type of facility-based physician. Proposed new §3.3705(l)(10) requires an insurer's preferred provider listing specifically identify those facilities at which the insurer has a contract with facility-based physicians that have an exclusive contract with the facility and to specify the physician type. Proposed §3.3705(l)(11) requires an insurer to specify in its provider listings the date on which each required element of information is provided to the insured. Proposed new §3.3705(m) requires insurers operating a preferred provider benefit plan that relies upon an access plan to provide notice of this fact to each individual and group policy holder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. Proposed new §3.3705(n) requires insurers provide notice on their website and in their online preferred provider listing of a substantial decrease in preferred facility-based physicians. Proposed §3.3705(o) requires that insurers make disclosures in all insurance policies, certificates, and outlines of coverage concerning the method of reimbursement of basic benefit services from nonpreferred providers. Proposed new §3.3705(p) specifies that any plan that uses a preferred provider service delivery network that does not comply with proposed network adequacy requirements for hospitals to disclose on the cover page of any insurance policy, certificate of coverage, or outline of coverage using the network that the plan has a "Limited Hospital Care Network."

Proposed new §3.3705(q) specifies that if a preferred provider benefit plan designated as an Approved Hospital Care Network (AHCN) no longer complies with the network adequacy requirements for hospitals under §3.3704 and does not correct such noncompliance within 30 days, the insurer is required to notify the Department in writing, cease marketing as an AHCN, and inform insureds of the change at the time of renewal.

The Department anticipates that the proposed amendments to §3.3705 will result in costs to comply for small and micro-business insurers. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to the proposed §3.3705 amendments that would minimize adverse economic impact on small or micro businesses. The Department considered exempting small or micro businesses from all or part of the new proposed requirements in §3.3705 but concluded that such exemptions would not adequately achieve the purpose of the proposed new requirements to ensure that consumers receive necessary information about health benefit plans so that they may conduct adequate comparisons and make informed decisions concerning the selection or retention of a health care plan. If the Department exempted small or micro businesses from any or all of the proposed §3.3705 requirements, the insureds of those small and micro-business insurers would be greatly disadvantaged. For example, if the Department exempted small or micro businesses from the requirement to provide network demographics, as required by proposed §3.3705(b)(14), consumers would be unable to make an "apples to apples" comparison of health plans when shopping for coverage. Another example is that while consumers would be able to determine the ratio of current insureds to pediatricians for large carriers, consumers would be unable to do so for small carriers. Similarly, consumers would be able to learn where within the state large carriers' networks are inadequate, as required by §3.3705(e)(2), but would be unable to do so for small carriers. Exempting small or micro-business insurers from §3.3705(k), which contains a remedy for consumers that rely upon recently obtained provider directories, could result in insureds of those plans being less able to rely upon the accuracy of those documents and less likely to have a remedy if a carrier fails to regularly update them. Exempting small or micro-business insurers from the requirements of §3.3705(o), which provides significant transparency regarding how insurers determine their out-of-network reimbursements could result in small or micro-business insurers utilizing inappropriate reimbursement methodologies, and thereby impose potentially significant and unexpected out of pocket expenses. Reducing or eliminating the notices to insureds of small and micro-business insurers that are required in §3.3705 could increase those insureds' potential liability for balance bill amounts. Exempting small or micro-business insurers from the new requirements of §3.3705 would result in their insureds not receiving information necessary to compare different health plans, understand the benefits and limitations of the health plans they enroll in, or to make informed choices regarding where they obtain their health care.

Therefore, the Department has reviewed each new requirement in §3.3705 and has determined that there are no alternatives to the proposed new requirements that would be sufficiently protective of the health and economic welfare of those consumers insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

IV. Cost to insurers concerning designations as a preferred provider, termination of preferred provider participation, and participation in review of process

*Proposed §3.3706(a)(5): Prohibition against avoiding high risk populations when selecting participating preferred providers and proposed §3.3706(c): Requirement to have a documented process for selection and retention of preferred providers that are adequately credentialed.* Proposed new §3.3706(a)(5) specifies that insurers cannot exclude physicians or providers because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization or because they treat or specialize in such populations. Proposed new §3.3706(c) requires that at a minimum, an insurer's credentialing standards are required to meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC. Under proposed §3.3706(c), an insurer is also required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed.

The Department anticipates that proposed new §3.3706(a)(5) and (c) could result in costs to comply for small and micro-business insurers that are not currently compliant with the proposed requirements. The cost of compliance with proposed new §3.3706(a)(5) and (c) will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered alternatives to proposed §3.3706(a)(5) and (c) that would minimize any adverse impact on small or micro businesses. For instance, the Department considered exempting small or micro businesses from all or part of these proposed provisions but concluded that such exemptions would not adequately achieve the purpose of the proposed provisions to ensure that insurers cannot refuse to contract with providers in high risk areas and that insurers contract only with providers who are adequately credentialed and in accordance with a documented process designed for this purpose. The proposed §3.3706(a)(5) prohibition is necessary to ensure that insurers afford all providers a fair, reasonable, and equivalent opportunity to apply to be and to be designated as preferred providers, as required by the Insurance Code §1301.051. The proposed prohibition also reflects the requirement of the Insurance Code §1301.058 that any economic profiling of providers conducted by insurers be adjusted to recognize the characteristics of a particular provider's practice that may account for variations from average costs. Additionally, the proposed §3.3706(a)(5) prohibition ensures that a health insurance policy providing for the use of preferred providers is not unjust as prohibited under the Insurance Code §1701.055(a)(2). Exempting insurers because of their smaller size from all or part of proposed §3.3706(a)(5) and (c) could also result in insureds covered by small and micro-business insurers making plan choices without knowledge that the small or micro-business insurer has chosen to exclude qualified providers for impermissible reasons that do not relate to the providers' qualifications or the quality of care that they provide or include providers whose credentials have not been verified.

Exempting insurers because of their smaller size from all or part of proposed §3.3706(a)(5) and (c) could also result in all medical and health care services and items contained in the package of benefits for which coverage is provided not being accessible or available as required in the Insurance Code §1301.006. For these reasons, the Department, in accordance with the Government Code §2006.002(c-1), has determined that there are no alternative methods of accomplishing the objectives of proposed §3.3706(a)(5) and (c) that will adequately protect the health and economic welfare of all insureds in Texas, including those insured by small or micro-business insurers, while minimizing any adverse economic impact on small or micro businesses.

V. Cost to insurers concerning waiver requirements due to failure to contract in local markets.

*Proposed §3.3707(b): Waiver of network adequacy standards due to failure to contract in local markets.* Under proposed §3.3707(a), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the insurer may seek a waiver from one or more network adequacy requirements. Proposed new §3.3707(b) requires an insurer seeking a waiver to file the request with the Department and submit a copy to any physician or provider named in the waiver. Proposed new §3.3707(e) requires an insurer seeking a waiver to file the renewal request with the Department annually at the same time the insurer files the annual network adequacy report required under proposed §3.3709. The Department anticipates that the proposed §3.3707 could result in costs to comply for small and micro-business insurers. The cost of compliance with the proposal will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department is not required to prepare a regulatory flexibility analysis as required in §2006.002(c)(2) of the Government Code regarding proposed §3.3707 because small or micro-business insurers are not required by statute or by this proposed rule to request a waiver. Therefore, those small and micro-business insurers that request a waiver do so at their own choice, and as a result, they agree to bear the additional costs required for compliance with this proposal. Nevertheless, the Department considered alternatives that could assist small or micro-business insurers in obtaining waivers, such as allowing small or micro-business insurers to seek waivers through electronic applications, making the size of the insurer an element to be considered in the grant of a waiver, or having waivers granted to smaller insurers be effective for more than one year. However, the Department concluded that such modifications would not adequately achieve the purpose of the proposed section. The purpose of requiring the mailing of waiver requests, rather than electronic filing, is to be consistent with current Chief Clerk procedures and not add additional expense to the state in creating new electronic processes. Permitting small and micro-business insurers to make electronic filings of waiver requests, while declining to permit large insurers to do so, would impose additional cost to the State at little cost savings to small or micro-business insurers. Section 3.3707 does not place any significant restrictions on the content of a waiver application, and, therefore, the Department is unable to reduce the content requirements for small and micro-business insurers. Section 3.3707 contemplates a process in which waivers are granted only in cases where the local market conditions justify the waiver and that the waiver last only so long as necessary. Insureds purchasing preferred provider benefit plans are entitled to adequate networks of providers within the advertised service area regardless of the size of the insurer, and easing the requirements of obtaining a waiver by making the size of the insurer a factor in the grant of the waiver would potentially harm insureds who might not have the same ability to access care as insureds of large insurers. Additionally, the Department does not anticipate that there will be significant additional expense to insurers in renewing their requests for previously granted waivers, but extending those waiver periods for small or micro-business insurer for longer periods than necessary could result in harm to insureds needing services that have been the subject of a waiver. Additionally, waivers are only necessary within the service area of the insurer. Small and micro-business insurers will be able to limit their service areas under the rule and thus limit the necessity to apply for waivers from the Department. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of §3.3707 while minimizing any adverse impact on small or micro businesses.

VI. Cost to insurers for payment of nonpreferred provider claims; related disclosures and waivers.

*Proposed §3.3708: Requirements for reimbursements of nonpreferred provider claims when no preferred provider is reasonably available, requirements concerning methodologies used to determine reimbursement of nonpreferred providers generally, and required disclosures.* Proposed §3.3708 generally applies to services provided by a nonpreferred provider when a preferred provider is not reasonably available to an insured. In such a case, the insurer is required to pay the claim at the preferred benefit coinsurance level as required pursuant to the Insurance Code §1301.005(b) and §1301.155(b). Proposed new §3.3708(b)(2) also requires the insurer to credit out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum. Proposed new §3.3708(c) more broadly requires that reimbursement of all nonpreferred providers be calculated pursuant to an appropriate methodology that meets specified criteria. Proposed new §3.3708(d) requires insurers to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan. Proposed §3.3708(e) imposes a disclosure requirement on insurers that applies when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured as provided in proposed §3.3708(a)(1) - (3). In such cases, the insurer is required to disclose with each explanation of benefits that the insured has the right to request three categories of reimbursement data in relation to the claim for comparison purposes. Section 3.3708(e) is proposed to apply effective January 1, 2012, and the Department proposes to provide for a six-month waiver process with respect to the disclosure in §3.3708(f).

The Department anticipates that proposed §3.3708 will result in costs to comply for small and micro-business insurers. The cost of compliance with proposed §3.3708 will not vary between large businesses and small or micro businesses. The Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department considered exempting small or micro-business insurers from all or part of the requirements in §3.3708, but determined that neither a full or partial exemption would be consistent with the objectives of the rule. The requirement in §3.3708(b)(1) that insurers pay out of network claims under the enumerated circumstances at the preferred benefit coinsurance level is identical to the statutory requirements under the Insurance Code §1301.005(b) and §1301.069 and thus could not be waived for small or micro-business insurers. The requirement in §3.3708(b)(2), that out of pocket amounts expended by consumers be credited to their deductible and out of pocket maximum, is intended to protect insureds who do not voluntarily choose to obtain services from out of network providers by giving the insureds credit for their actual out of pocket expenses in the same manner they would receive such credit if they had received services from a contracted provider. Waiver or modification of this requirement for small or micro-business insurers could unfairly subject the insureds of these small and micro-business insurers to greater health care expenses. The requirements in proposed §3.3708(c) for standardized methodologies for out of network claim reimbursements will help to ensure that reimbursement rates are based upon relevant, current, and statistically valid data. Accordingly, the potential unexpected balance billing to which insureds are subjected as a result of health care emergencies and inadequate networks may be mitigated, giving both providers and insureds greater confidence that the methodologies underlying reimbursement determinations are appropriate. Furthermore terms used in preferred provider benefit plan documents will have consistent meanings as applied by different insurers, and will provide clear standards to the Department to apply when reviewing the appropriateness of out of network reimbursement methodologies. Wavier or modification of these requirements for small or micro-business insurers could result in such insurers utilizing inappropriate methodologies to the detriment of their insureds and result in insureds and providers of small and micro-insurers encountering significant inconsistencies in payments within the market. The requirement in proposed new §3.3708(d) to pay all covered basic benefits for services obtained from health care providers or physicians at the plan's basic level of coverage, regardless of whether the service is provided within the designated service area for the plan, is necessary to ensure that health insurance policies do not restrict an insured's access to the basic health care services to which the insured is entitled as part of the benefit package as specified in the Insurance Code §1301.005. Wavier or modification of the proposed §3.3708(d) requirement for small or micro-business insurers could result in their insureds having no coverage when services are rendered outside of the service area of a small of micro-business insurer. This could result in substantial financial hardship for insureds of small and micro-business insurers. The disclosure required by §3.3708(e) is necessary to provide important information to insureds faced with the financial consequences of unanticipated balance bills that arise due to the need for emergency care or due to the failure of the insurer to provide an adequate network. The disclosure required by §3.3708(e) will provide insureds the ability to obtain information on request to evaluate the reimbursement made by the insurer and the payment requested by the provider and to determine whether to request mediation as permitted under the Insurance Code §1467.054 for eligible claims or to otherwise contest the billed charge. Waiver or modification of the §3.3708(e) requirement for small or micro-business insurers would unfairly leave insureds of such insurers without information necessary to evaluate balance bills that they receive.

In accordance with the Government Code §2001.001(c-1), the Department has reviewed every provision of §3.3708 and has determined that there are no alternatives to these provisions that would be sufficiently protective of the health and economic welfare of those consumers insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

VII. Cost to insurers for annual network adequacy and access plan reports.

*Proposed §3.3709(a) and §3.3709(d): Requirement to file a network adequacy report and local market access plan, if applicable, with the Department annually before April 1 and prior to marketing any plan in a new service area. Proposed new §3.3709(a) requires an insurer to file a network adequacy report with the Department on or before April 1 of each year and prior to marketing any plan in a new service area.* Proposed new §3.3709(d) requires an insurer to submit a local market access plan if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements in §3.3704. Proposed new §3.3709(f)(1)(A) requires insurers to establish and implement documented procedures for use in all service areas for which a §3.3709(d) local market access plan is submitted. Under proposed §3.3709(f)(1)(A), an insurer must utilize a documented procedure to identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer. Proposed §3.3709(f)(1)(B) requires an insurer to establish and implement documented procedures for use in all service areas for which a local market access plan is submitted to furnish insureds an estimate of the amount the insurer will pay the out-of-network physician or provider prior to their services being rendered. Proposed §3.3709(f)(1)(C) requires an insurer to notify the insured of potential liability for any amounts charged by the physician or provider that are not paid in full by the insurer. Proposed §3.3709(f)(2) requires that insurers utilize a documented procedure to identify claims filed by non-preferred providers in instances in which no preferred provider was reasonably available to the insured; and to make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level. Proposed §3.3709(h) requires that insurers file annual network adequacy reports and access plans, if applicable, electronically to the Department using Microsoft Word or Excel documents. Proposed §3.3709(i) requires that insurers establish an access plan within 30 days of the date on which their network becomes noncompliant with the network adequacy requirements specified in §3.3704.

The Department anticipates that proposed §3.3709 will result in costs to comply for small and micro-business insurers. The cost of compliance with proposed §3.3709 will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses. The Department considered exempting small or micro-business insurers from all or part of the requirements in §3.3709 but determined that neither a full or partial exemption would be consistent with the objectives of the rule. The objectives of proposed §3.3709 are to permit ongoing monitoring of insurer compliance with network adequacy standards by the Department and to ensure that insurers are

taking reasonable steps to reduce the potential scope of unanticipated balance bills. If small or micro-business insurers were fully or partially exempted from these requirements, the Department would not be able to adequately monitor their compliance, and their insureds could face greater risk of financial hardship due to balance billing.

In accordance with the Government Code §2001.001(c-1), the Department has reviewed every provision of §3.3709 and has determined that there are no alternatives to these provisions that would be sufficiently protective of the health and economic welfare of those consumers insured by small and micro-business insurers that would also minimize any adverse economic impact on small or micro businesses.

VIII. Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements

*Proposed §3.3713: Submission and disclosure of information concerning the effects of uncompensated care and waiver of requirements.* Proposed §3.3713 is not effective until the expiration of seven years from the effective date of the section. At that time, insurers are required under §3.3713(a) to initiate an annual reporting requirement that provides to the Department, in accordance with the requirements of §3.3713(b), the following information: (i) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and (ii) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility. Effective at the expiration of eight years from the effective date of §3.3713, proposed §3.3713(c) requires insurers to make the information concerning the effects of uncompensated care as reported to the Department publicly available and to provide notice of the availability of such information in each policy, certificate, and outline of coverage. Proposed §3.3713(d) requires that an insurer's contract with a facility contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required under §3.3713. Proposed §3.3713(a) - (d) is necessary to provide information to both the Department and the interested public concerning the relationship of uncompensated care to health care costs incurred by insurers and insureds. Information concerning the impact of uncompensated care upon health care fees and insurance premium rates will help insureds to educate themselves concerning possible barriers to improved networks of preferred providers and factors influencing health insurance premium rates. Proposed §3.3713(e) - (g) establish a six-month waiver process for the requirements of §3.3713 to provide flexibility to an insurer that has particular circumstances that would justify such delay. These circumstances include (i) undue hardship, including financial or operational hardship; (ii) the geographical area in which the insurer operates; and (iii) total number of insureds covered by the insurer. These requirements could enable small or micro-business insurers to obtain a six-month waiver if they meet the specified requirements for the waiver.

The Department anticipates that proposed §3.3713(a) - (d) will result in costs to comply for small and micro-business insurers. The cost of compliance with the these proposed requirements will not vary between large businesses and small or micro businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note part of this proposal is equally applicable to small or micro businesses.

The Department has considered exempting small or micro-business insurers from all or part of the requirements in §3.3713(a) - (d), but has determined that neither a full or partial exemption would be consistent with the objectives of the rule, which is to provide the Department and the prospective and current insureds of all insurers, regardless of size, information on the impact of uncompensated care on insurance premium rates and network adequacy. A full or partial exemption from the information submission requirement would prevent the Department from developing a full analysis of the adequacy of the networks of small and micro-business insurers and the basis of their premium rates. It would also prevent prospective and current insureds of small and micro-business insurers from being able to adequately compare coverages and networks offered by different insurers and assess premium rates being charged. The Department has included a six-month waiver process, which will take into consideration issues of undue hardship and the number of insureds impacted, potentially allowing for the consideration of the size of the insurer requesting the waiver.

The Department also considered having more limited requirements for the submission of waiver requests in the case of small or micro-business insurers, but determined that the current submission requirements are not amenable to being limited because they already grant such broad latitude to insurers in justifying the grant of a waiver.

Thus, in accordance with §2006.002(c-1) of the Government Code, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §3.3713(a) - (d) and of protecting the health and economic welfare of Texas insureds while minimizing adverse impacts on small or micro businesses.

TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on February 28, 2011, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Doug Danzeiser, Deputy Commissioner for Regulatory Matters, Life, Health and Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The Commissioner will consider the proposed amendments to §§3.3701 - 3.3706 and new §§3.3707 - 3.3713 in a public hearing under Docket No. 2726 scheduled for February 8, 2011, at 9:30 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered. A separate and additional notice of this public hearing was submitted to the Office of the Secretary of State on January 14, 2011, for publication in the January 28, 2011, issue of the *Texas Register.* The notice specifies the availability of the Department's proposal by means of the following Internet link: http://www.tdi.state.tx.us/alert/agenda.html effective January 14, 2011.

STATUTORY AUTHORITY. The amendments and new sections are proposed pursuant to: (i) the Insurance Code §§521.102, 544.002(a)(2), 544.052, 1301.0046, 1301.005, 1301.0055, 1301.006, 1301.007, 1301.051, 1301.058, 1301.069, 1301.155(b), 1301.158(b) and (d), 1301.159,

1301.1591, 1301.161, 1451.053, 1451.054(a), 1451.104(a) and (b), 1456.003(c), 1456.007, 1467.051(a), 1467.053(d), 1467.054(a), 1661.005, 1701.055(a)(2), and 36.001; (ii) the Health and Safety Code §324.101(d); and (iii) the Occupations Code §101.352(c). Section 521.102 requires an insurer to maintain a toll-free number to provide information concerning its policies and to receive complaints from policyholders. Section 544.002(a)(2) prohibits an insurer from charging an individual a rate that differs from the rate charged to other individuals for the same coverage because of the individual's geographic location. Section 544.052 prohibits an insurer from engaging in or permitting unfair discrimination between individuals of the same class and essentially the same hazard, including unfair discrimination in: (i) the amount of premium, policy fees, or rates charged for a policy or contract of insurance; (ii) the benefits payable under a policy or contract of insurance; or (iii) any of the terms or conditions of a policy or contract of insurance. Section 1301.0046 provides that an insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Section 1301.005 requires that: (i) an insurer offering a preferred provider benefit plan ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area; and (ii) if services are not available through a preferred provider within the service area, an insurer is required to reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider. Section 1301.0055 requires the Commissioner to adopt by rule network adequacy standards that: (i) are adapted to local markets where an insurer offers a preferred provider benefit plan; (ii) ensure availability of, and accessibility to, a full range of contracted physicians and health care providers to provide health services to insureds; and (iii) on good cause shown, may allow departure from local market network adequacy standards if the Commissioner posts on the Department's Internet website the name of the preferred provider plan, the insurer offering the plan, and the affected local market. Section 1301.006 requires that an insurer that markets a preferred provider benefit plan contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Section 1301.007 authorizes the Commissioner to adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services to Texas residents. Section 1301.051 provides that an insurer: (i) is required to afford a fair, reasonable, and equivalent opportunity to apply to be and to be designated as a preferred provider to practitioners and institutional providers and to health care providers other than practitioners and institutional providers, if those other health care providers are included by the insurer as preferred providers, provided that the practitioners, institutional providers, or health care providers are licensed to treat injuries or illnesses or to provide services covered by a health insurance policy and comply with the terms established by the insurer for designation as preferred providers; (ii) is prohibited from unreasonably withholding a designation as a preferred provider; (iii) is required to give a physician or health care provider who, on the person's initial application, is not designated as a preferred provider written reasons for denial of the designation; and (iv) is prohibited from withholding a designation to a podiatrist described by Section 1301.0521.

Section 1301.058 requires that: (i) an insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured; and (ii) economic profiles be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs. Section 1301.069 specifies that the provisions of Chapter 1301 relating to prompt payment by an insurer of a physician or health care provider and to verification of medical care or health care services apply to a nonpreferred provider who furnishes to an insured: (i) care related to an emergency or its attendant episode of care as required by state or federal law; or (ii) specialty or other medical care or health care services at the request of the insurer or a preferred provider because the services are not reasonably available from a preferred provider who is included in the preferred delivery network.

Section 1301.155(b) specifies that if an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider: (i) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists; (ii) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and (iii) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition. Section 1301.158(b) requires an insurer to provide a current or prospective group contract holder or insured on request with an accurate written description of the terms of the health insurance policy to allow the individual to make comparisons and an informed decision before selecting among health plans. The description must be in a readable and understandable format as prescribed by the Commissioner and must include a current list of preferred providers.

Section 1301.158(d) requires an insurer to provide to an insured on request information on: (i) whether a physician or other health care provider is a participating provider in the insurer's preferred provider network; (ii) whether proposed health care services are covered by the health insurance policy; (iii) what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and (iv) coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's usual and customary reimbursement rate for out-of-network services.

Section 1301.159 requires insurers to provide a current list of preferred providers at least annually. Section 1301.1591: (i) requires an insurer subject to Chapter 1301 that maintains an Internet site to list on the Internet site the preferred providers, including, if appropriate, mental health providers and substance abuse treatment providers, that insureds may use in accordance with the terms of the insured's preferred provider benefit plan.; (ii) requires that the listing identify those preferred providers who

continue to be available to provide services to new patients or clients; (iii) requires the insurer to update such Internet sites at least quarterly; and (iv) authorizes the Commissioner to adopt rules as necessary to implement the section, specifying that the rules may govern the form and content of the information required to be provided. Section 1301.161 prohibits an insurer from engaging in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has: (i) filed a complaint against the insurer or against a preferred provider; or (ii) appealed a decision of the insurer.

Section 1451.053 prohibits an accident and health insurance policy from making a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize. Section 1451.054(a) mandates that a provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section. Section 1451.104(a) prohibits an insurer from classifying, differentiating, or discriminating between scheduled services or procedures provided by a health care practitioner selected under the subchapter and performed in the scope of that practitioner's license and the same services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to: (i) the payment schedule or payment provisions of the policy; or (ii) the amount or manner of payment or reimbursement under the policy. Section 1451.104(b) prohibits an insurer from denying payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under the subchapter.

Section 1456.003(c) requires a preferred provider benefit plan to clearly identify any health care facilities within the provider network in which facility-based physicians do not participate in the plan's provider network and specifies that health care facilities identified under the subsection are required to be identified in a separate and conspicuous manner in any provider network directory or website directory. Section 1456.007 requires a preferred provider benefit plan to, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and to specify any deductibles, copayments, coinsurance, or other amounts for which the enrollee is responsible. The preferred provider benefit plan must advise the enrollee that: (i) the actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and (ii) the enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

Section 1467.051(a) specifies that an enrollee may request mediation of a settlement of an out-of-network health benefit claim if: (i) the amount for which the enrollee is responsible to a facility-based physician, after copayments, deductibles, and coinsurance, including the amount unpaid by the administrator or insurer, is greater than $1,000; and (ii) the health benefit claim is for a medical service or supply provided by a facility-based physician in a hospital that is a preferred provider or that has a contract with the administrator. Section 1467.053(d) provides that a facility-based physician who makes a disclosure under §1467.053(c) and obtains the enrollee's written acknowledgment of that disclosure may not be required to mediate a billed charge under the subchapter if the amount billed is less than or equal to the maximum amount projected in the disclosure. Section 1467.054(a) authorizes an enrollee to request mandatory mediation under the chapter.

Section 1661.005 requires physicians, hospitals, or other health care providers that receive an overpayment from an enrollee to refund the amount of the overpayment to the enrollee no later than the 30th day after the date the physician, hospital, or health care provider determines that an overpayment has been made. Section 1701.055(a)(2) authorizes the Commissioner to disapprove or, after notice and hearing, withdraw approval of a form if the form contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive, subject to the exception specified in subsection (d) of the section. The Health and Safety Code §324.101(d) requires a facility to provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The facility must advise the consumer that: (i) the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service; (ii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service; (iii) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor; (iv) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or other service depending on the consumer's health benefit plan coverage; and (v) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service.

The Occupations Code §101.352(c) mandates that on the request of a patient who is seeking services that are to be provided on an out-of-network basis or who does not have coverage under a government program, health insurance policy, or health maintenance organization evidence of coverage, a physician shall provide an estimate of the charges for any health care services or supplies. A physician must advise the consumer that: (i) the request for an estimate of charges may result in a delay in the scheduling and provision of the services; (ii) the actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services; (iii) the actual charges for the services or supplies may differ from the amount to be paid by the patient or the patient's third-party payor; and (iv) the patient may be personally liable for payment for the services or supplies depending on the patient's health benefit plan coverage. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

§3.3701: Insurance Code §§843.002, 1301.001 - 1301.202, 1353.001, 1353.002, 1451.001, 1451.053, 1451.054, and 1451.101 - 1451.127

§3.3702: Insurance Code §§1301.001 - 1301.202, and 4201.002; Health and Safety Code Chapters 241, 243, 244, Title 7, Subtitle C

§3.3703: Insurance Code Chapter 542, Subchapter A; §§1301.001 - 1301.202, 1456.007, and 1661.005; Occupations Code Chapters 551 - 566 and 568 - 569

§3.3704: Insurance Code Chapter 542, Subchapter A; §§544.051 - 544.054; 1251.005, 1251.006, 1301.001 - 1301.202, 1451.001, 1451.053, 1451.054, 1451.101 - 1451.127, 1701.002 - 1701.005; 1701.051 - 1701.060; 1701.101 - 1701.103, and 1701.151; and Chapter 4201

§3.3705: Insurance Code §§521.102, 1301.001 - 1301.202, 1456.003, 1456.007, 1467.051, 1467.053, 1467.054, and 1701.055; Health and Safety Code §324.101(d); and Occupations Code §101.352(c)

§3.3706: Insurance Code §§1301.001 - 1301.202, and 1701.055

§3.3707: Insurance Code §§1301.001 - 1301.202

§3.3708: Insurance Code §§1301.001 - 1301.202, 1467.054, and 1701.055

§3.3709: Insurance Code §§83.001 - 83.153, and 1301.001 - 1301.202

§3.3710 and §3.3711: Insurance Code §§1301.001 - 1301.202

§3.3712: Insurance Code §§1301.001 - 1301.202, and 1467.051

§3.3713: Insurance Code §§1301.001 - 1301.202

*§3.3701. Application.*

(a) Except as otherwise specified in this subchapter, the [~~The~~] sections of this subchapter apply to any preferred provider benefit plan as specified in this subsection.

(1) This subchapter applies to any preferred provider benefit plan policy delivered, issued for delivery, or renewed on or after June 1, 2011. Any preferred provider benefit plan policy delivered, issued for delivery, or renewed prior to June 1, 2011, is subject to the statutes and provisions of this subchapter in effect at the time the policy was delivered, issued for delivery, or renewed.

(2) The sections of this subchapter do not apply to provisions for dental care benefits in any health insurance policy.

(b) This subchapter is not an interpretation of and has no application to any law requiring licensure to act as a principal or agent in the insurance or related businesses including, but not limited to, health maintenance organizations.

(c) [~~(b)~~] The provisions of this subchapter are [~~shall be~~] subject to the Insurance Code §§1451.001, 1451.053, and 1451.054; Chapter 1301; §§1451.101 - 1451.127; and §1353.001 and §1353.002 [~~Articles 3.70-2(B), 3.70-3C (Preferred Provider Benefit Plans), 3.70-3C (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans), 21.52, and 21.53K~~] as they relate to insurers and the practitioners named therein.

(d) [~~(c)~~] These sections do not create a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action. These sections do not abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available.

(e) [~~(d)~~] If a court of competent jurisdiction holds that any provision [~~terms, sections or subsections~~] of this subchapter or its application to any person or circumstance is [~~are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code or~~] invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable [~~remaining terms, sections, or subsections of this subchapter will continue in effect~~].

*§3.3702. Definitions.*

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(2) [~~(1)~~] Contract holder--An individual who holds an individual health insurance policy, or an organization which holds a group health insurance policy.

(3) [~~(2)~~] Emergency care--As defined in the Insurance Code §1301.155 [~~Article 3.70-3C §1(1) (Preferred Provider Benefit Plans)~~].

(4) Facility--

(A) an ambulatory surgical center licensed under the Health and Safety Code Chapter 243;

(B) a birthing center licensed under the Health and Safety Code Chapter 244; or

(C) a hospital licensed under the Health and Safety Code Chapter 241.

(5) Facility-based physician--A radiologist, an anesthesiologist, a pathologist, an emergency department physician, or a neonatologist:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(6) General practitioner--A physician providing general medical care and treatment for acute and chronic conditions to patients of all ages rather than focusing on a specific specialty.

(7) [~~(3)~~] Health care provider or provider--As defined in the Insurance Code §1301.001(1) [~~Article 3.70-3C §1(3) (Preferred Provider Benefit Plans)~~].

(8) [~~(4)~~] Health insurance policy--As defined in the Insurance Code §1301.001(2) [~~Article 3.70 - 3C §1(2) (Preferred Provider Benefit Plans)~~].

(9) [~~(5)~~] Health maintenance organization [~~Maintenance Organization~~] (HMO)--As defined in the Insurance Code §843.002(14) [~~Article 20A.02(n)~~].

(10) [~~(6)~~] Hospital--As defined in the Insurance Code §1301.001(3), a licensed public or private institution as defined by the Health & Safety Code Chapter 241 or the Health & Safety Code Title 7, Subtitle C [~~Article 3.70-3C §1(4) (Preferred Provider Benefit Plans)~~].

(11) [~~(7)~~] Institutional provider--As defined in the Insurance Code §1301.001(4) [~~Article 3.70-3C §1(5) (Preferred Provider Benefit Plans)~~].

(12) [~~(8)~~] Insurer--As defined in the Insurance Code §1301.001(5) [~~Article 3.70-3C §1(6) (Preferred Provider Benefit Plans)~~].

(13) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(14) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(15) Pediatric practitioner--A physician with appropriate education, training and experience whose practice is limited to providing medical and health care services to children and young adults.

(16) [~~(9)~~] Physician--As defined in the Insurance Code §1301.001(6) [~~Article 3.70-3C §1(8) (Preferred Provider Benefit Plans)~~].

(17) [~~(10)~~] Practitioner--As defined in the Insurance Code §1301.001(7) [~~Article 3.70-3C §1(9) (Preferred Provider Benefit Plans)~~].

(18) [~~(11)~~] Preferred provider--As defined in the Insurance Code §1301.001(8) [~~Article 3.70-3C §1(1) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(19) [~~(12)~~] Preferred provider benefit plan [~~Provider Benefit Plan~~]--As defined in the Insurance Code §1301.001(9) [~~Article 3.70-3C §1(2) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(20) [~~(13)~~] Prospective insured--As defined in the Insurance Code §1301.158(a) [~~Article 3.70-3C §1(11) (Preferred Provider Benefit Plans)~~].

(21) [~~(14)~~] Quality assessment--As defined in the Insurance Code §1301.059(a) [~~Article 3.70-3C §1(12) (Preferred Provider Benefit Plans)~~].

(22) Rural area--

(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;

(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or

(C) any other area designated as rural under rules adopted by the commissioner, notwithstanding subparagraphs (A) and (B) of this paragraph.

(23) [~~(15)~~] Service area--As defined in the Insurance Code §1301.001(10) [~~Article 3.70-3C §1(13) (Preferred Provider Benefit Plans)~~].

(24) Specialist--A physician who, by virtue of completing specialized education and specialized training, or by earning a board certification or fellowship, provides care that is narrow in scope, including care that is limited to one or more organ systems and whose primary practice is not as a general practitioner.

(25) Urgent care--Health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

(26) [~~(16)~~] Utilization review [~~Review~~]--As defined in the Insurance Code §4201.002(13) [~~Article 21.58A §2(20)~~].

*§3.3703. Contracting Requirements.*

(a) An insurer marketing a preferred provider benefit plan is required to [~~must~~] contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract is required to [~~must~~] meet the following requirements:

(1) A contract between a preferred provider and an insurer may [~~shall~~] not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider organizations, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is [~~,~~] contained in a contract between a preferred provider and an insurer is required to [~~, shall~~] be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that [~~which~~] include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider may [~~shall~~] not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition is limited in subparagraphs (A) - (C) of this paragraph:

(A) with respect to physicians or practitioners that are members of a practice group that includes 15 or more physicians or practitioners, the contracting prohibition of this paragraph shall not apply after June 1, 2014;

(B) with respect to physicians or practitioners that are members of a practice group that includes at least 7 and not more than 14 physicians or practitioners, the contracting prohibition of this paragraph shall not apply after June 1, 2016; and

(C) notwithstanding subparagraphs (A) and (B) of this paragraph, with respect to any practice group of physicians or providers that has not previously held staff membership or privileges with a hospital or institutional provider and acquires such membership or privileges, the contracting prohibition of this paragraph applies for the first three years of such membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may [~~shall~~] not require the preferred provider to pay hospital, institutional, laboratory, x-ray, or

like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may [~~shall~~] not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may [~~shall~~] not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's [~~A~~] contract with [~~between~~] a physician, physician [~~physicians'~~] group, or practitioner [~~and an insurer~~] is required to [~~shall~~] have a mechanism for the resolution of complaints that are initiated by an insured, a physician, physician [~~physicians'~~] group, or practitioner. The mechanism must provide [~~which provides~~] for reasonable due process including, in an advisory role only, a review panel selected as specified [~~by the manner set forth~~] in subsection (b)(2) of §3.3706 of this subchapter [~~title~~] (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may [~~shall~~] not require any health care provider, physician, or physician [~~physicians'~~] group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must [~~shall~~] require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must [~~shall~~] require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims, including the Insurance Code Chapter 1301, Subchapter C [~~Article 3.70-3C §3A (Prompt Payment of Preferred Providers)~~] and §§21.2801 - 21.2820 of this title (relating to Submission of Clean Claims) with respect to payment to the provider for covered services that are rendered to insureds.

(12) A contract between a preferred provider and an insurer must [~~shall~~] require the provider to comply with the Insurance Code §§1301.152 - 1301.154 [~~Article 3.70-3C §4 (Preferred Provider Benefit Plans)~~], which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may [~~shall~~] not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in the Insurance Code §1301.067 [~~Article 3.70-3C §7(c) (Preferred Provider Benefit Plans)~~] about any of the matters set forth therein.

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must [~~shall~~] require the insurer to inform the provider of the insurer's obligation to comply with the Insurance Code §1301.058 [~~Article 3.70-3C §3(h) (Preferred Provider Benefit Plans)~~].

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to [~~shall~~] disclose in the contract all requirements of the Insurance Code §1301.059(b) [~~Article 3.70-3C §3(i) (Preferred Provider Benefit Plans)~~].

(16) A contract between a preferred provider and an insurer may [~~shall~~] not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may [~~shall~~] not prohibit a pharmacist from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, [~~Article 4542a-1, Texas Civil Statutes~~] and rules promulgated thereunder.

(18) A contract between a preferred provider and an insurer must [~~shall~~] require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must [~~shall~~] require the insurer to provide assistance to the provider as set forth in the Insurance Code §1301.160(b) [~~Article 3.70-3C §6(e)(2) (Preferred Provider Benefit Plans)~~].

(19) A contract between a preferred provider and an insurer must [~~shall~~] require written notice to the provider upon termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must [~~shall~~] include the provider's right to request a review, as specified [~~set forth~~] in §3.3706(d) [~~§3.3706(c)~~] of this subchapter [~~title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process)~~].

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including e-mail, computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided pursuant to this paragraph are required to [~~must~~] be made in accordance with subparagraph (D) of this paragraph. The insurer is required to [~~shall~~] provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to [~~must~~] include a preferred provider specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to [~~must~~] include:

*(i)* a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes, and modifiers:

*(I)* by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

*(II)* that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

*(ii)* all applicable coding methodologies;

*(iii)* all applicable bundling processes, which are required to [~~must~~] be consistent with nationally recognized and generally accepted bundling edits and logic;

*(iv)* all applicable downcoding policies;

*(v)* a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

*(vi)* any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided pursuant to this paragraph; and

*(vii)* the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to [~~shall~~] clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may [~~shall~~] be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to [~~must~~] supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will [~~shall~~] be effective as to the preferred provider, unless the insurer provides at least 90 calendar days written notice to the preferred provider identifying with specificity the amendment, revision or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon receipt of a request, the insurer is required to [~~must~~] provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

*(i)* may not use or disclose the information for any purpose other than:

*(I)* the preferred provider's practice management; [~~,~~]

*(II)* billing activities; [~~,~~]

*(III)* other business operations; [~~,~~] or

*(IV)* communications with a governmental agency involved in the regulation of health care or insurance [~~and~~];

*(ii)* may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

*(iii)* may not rely upon information provided pursuant to this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to [~~shall~~] assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to [~~shall~~] include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured, if applicable:

(A) that the physician, provider, or facility to whom the insured is being referred is not a preferred provider; and

(B) that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay

of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of the Insurance Code §1661.005 (relating to refunds of overpayments from enrollees).

(26) A contract between an insurer and a facility must require that:

(A) the facility give notice to the insurer as soon as reasonably practicable but not later than the fifth business day following the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer; and

(B) the facility require facility-based physicians providing services at the facility to comply with the requirements specified in clauses (i) and (ii) of this subparagraph.

*(i)* A provision of the contract must require facility-based physicians to make disclosure to the general public of the typical range of the physician's billed charges for no fewer than those professional services identified in §3.3712 of this subchapter (relating to Facility-Based Physician Disclosure of Certain Billed Charges), represented in that section by CPT codes as published by the American Medical Association.

*(ii)* A provision of the contract must require facility-based physicians to provide responsive information no more than annually to surveys of physician fees conducted by the department or by an academic institution conducting the survey on behalf of the department.

(b) In addition to all other contract rights, violations of these rules will [~~shall~~] be treated for purposes of complaint and action in accordance with the Insurance Code Chapter 542, Subchapter A [~~Article 21.21-2~~], and the provisions of that subchapter will [~~article shall~~] be utilized insofar as practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of the Insurance Code Chapter 1301 [~~Article 3.70-3C (Preferred Provider Benefit Plans)~~] and this subchapter; or

(2) ensure that the requirements of the Insurance Code Chapter 1301 [~~Article 3.70-3C (Preferred Provider Benefit Plans)~~] and this subchapter are met.

*§3.3704. Freedom of Choice; Availability of Preferred Providers.*

(a) Fairness Requirements. A preferred provider benefit plan is [~~shall~~] not [~~be~~] considered unjust under the Insurance Code §§1701.002 - 1701.005; §§1701.051 - 1701.060; §§1701.101 - 1701.103; and §1701.151 [~~Article 3.42~~], or to unfairly discriminate [~~unfair discrimination~~] under the Insurance Code Chapter 542, Subchapter A, [~~Articles 21.21-6~~] or §§544.051 - 544.054 [~~21.21-8~~], or to violate §§1451.001, 1451.053, 1451.054 [~~Articles 3.70-2(B)~~] or §§1451.101 - 1451.127 [~~21.52~~] of the Insurance Code provided that:

(1) pursuant to the Insurance Code §§1251.005, 1251.006, 1301.003, 1301.004, 1301.006, 1301.051, 1301.053, 1301.054, 1301.055, 1301.057 - 1301.062, 1301.064, 1301.065, 1301.151, 1301.156, and 1301.201 [~~Article 3.70-3C §3 (Preferred Provider Benefit Plans), Article 3.51-6, (3, and Article 3.70-3(A)(9)~~], the [~~no~~] preferred provider benefit plan does not [~~may~~] require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are [~~shall be~~] provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds [~~shall~~] have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds [~~shall~~] have the right to continuity of care as set forth in the Insurance Code §§1301.152 - 1301.154 [~~Article 3.70-3C, §4 (Preferred Provider Benefit Plans)~~];

(5) insureds [~~shall~~] have the right to emergency care services as set forth in the Insurance Code §1301.155 [~~Article 3.70-3C, §5 (Preferred Provider Benefit Plans)~~];

(6) the basic level of coverage, excluding a reasonable difference in deductibles, is not more than 50 percent [~~30%~~] less than the higher level of coverage. A reasonable difference in deductibles is [~~shall be~~] determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider are not restricted by the insurer;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the basic level of coverage is [~~must be~~] reasonably consistent with such other health insurance policies offered by the insurer that [~~which~~] do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan is [~~shall be~~] taken pursuant to the Insurance Code Chapter 4201 [~~Article 21.58A~~] and Chapter 19, Subchapter R of this title (relating to Utilization Review Agents);

[~~(10) if covered services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as preferred providers. Nothing in this section requires reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience;~~]

(10) [~~(11)~~] a preferred provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider[~~,~~] only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this subchapter [~~title~~] (relating to Nature of Communications with Insureds; Readability, [~~and~~] Mandatory Disclosure Requirements, and Plan Designations); and

(11) [~~(12)~~] both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) Payment of Nonpreferred Providers. Payment by the insurer must [~~shall~~] be made for services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(c) Retaliatory Action Prohibited. An insurer is prohibited from engaging [~~shall not engage~~] in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint against the insurer or a preferred provider or has appealed a decision of the insurer.

(d) Access to Certain Institutional Providers. In addition to the requirements for availability of preferred providers set forth in the Insurance Code §1301.005 [~~Article 3.70-3C §8 (Preferred Provider Benefit Plans)~~], any insurer offering a preferred provider benefit plan is required to [~~shall~~] make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under such plan freedom of choice in the selection of institutional providers at which they will receive care, unless such a mix proves to be not feasible due to geographic, economic, or other operational factors. An insurer is required to [~~shall~~] give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.

(e) Network Requirements. Each preferred provider benefit plan is required to include a health care service delivery network that complies with the Insurance Code §1301.005 and §1301.006 and the local market adequacy requirements described in this section. An adequate network is required to:

(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:

(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(B) projected utilization of covered health care services;

(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;

(3) include sufficient numbers and types of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;

(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;

(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;

(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;

(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;

(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:

(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(B) 75 miles for specialty care and specialty hospitals;

(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;

(10) ensure that routine care is available and accessible from preferred providers:

(A) within three weeks for medical conditions; and

(B) within two weeks for behavioral health conditions;

(11) ensure that preventive health services are available and accessible from preferred providers:

(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and

(B) within three months for an adult.

(f) Network Monitoring and Corrective Action. Insurers are required to monitor compliance with subsection (e) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate.

(g) Service Areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide are required to be defined in terms of one of the following:

(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this subchapter (relating to Geographic Regions);

(2) one or more Texas counties; or

(3) the first three digits of ZIP Codes in Texas.

*§3.3705. Nature of Communications with Insureds; Readability, [~~and~~] Mandatory Disclosure Requirements, and Plan Designations.*

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications or riders are required to [~~shall~~] be written in a readable and understandable format that meets the requirements of §3.602 of this chapter [~~title~~] (relating to Plain Language Requirements [~~for Health Benefit Policies~~]).

(b) Disclosure of Terms and Conditions of the Policy. The insurer is required [~~shall~~], upon request, to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy that [~~which~~] allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection including the level of disclosure required. The written description is required to [~~must~~] be in a readable and understandable format, by category, and is required to [~~must~~] include a clear, complete, and accurate description of these items in the following order:

(1) a statement that the entity providing the coverage is an insurance company, the name of the insurance company, and that the insurance contract contains preferred provider benefits;

(2) a toll free number, unless exempted by statute or rule, and address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and prescription drug coverage, both generic and name brand;

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any prior authorizations, including preauthorization review, concurrent review, post-service review, and postpayment review; and any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) a current list of preferred providers and complete descriptions of the provider networks, including names and locations of physicians and health care providers, and a disclosure of which preferred providers will not accept new patients, both of which may be provided electronically with the agreement of the insured provided that information about how to obtain a nonelectronic provider listing free of charge is also provided; [~~and~~]

(13) the service area(s); and [~~area.~~]

(14) information that is updated at least annually regarding the following network demographics for each service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this subchapter (relating to Geographic Regions), if the plan is offered on a statewide service area basis:

(A) the number of insureds in the service area or region;

(B) for each provider area of practice, including at a minimum internal medicine, family/general practice, pediatrics, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery:

*(i)* the number of preferred providers and the ratio of insureds to providers in the plan, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan) applies to the services furnished by that type of provider in the service area or region and how such access plan may be obtained or viewed, if applicable;

*(ii)* the percentage of preferred providers that are accepting new patients; and

*(iii)* the percentage of preferred providers with board certifications in the area of practice, as applicable;

(C) for hospitals:

*(i)* the number of preferred provider hospitals in the service area or region and the ratio of insureds to hospital beds, as well as an indication of whether an active access plan pursuant to §3.3709 of this subchapter applies to hospital services in that service area or region and how the access plan may be obtained or viewed;

*(ii)* the percentage of preferred provider hospitals in the service area or region accredited by a nationally recognized accreditation organization; and

*(iii)* the average surgical site infection rate at each specific preferred provider hospital in the service area or region.

(c) Filing Required. A copy of the written description required in subsection (b) of this section must [~~shall~~] be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Electronic submission of the provider listing, if applicable, must be submitted to the following e-mail address: hwcn@tdi.state.tx.us. Nonelectronic filings are required to be submitted to the department at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104.

(d) Promotional Disclosures Required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan are required to [~~shall~~] clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits is required to [~~must~~] be in close proximity to an equally prominent description of basic benefits.

(e) Internet Website Disclosures. Insurers that maintain an Internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds are required to provide:

(1) an Internet-based provider listing for use by current insureds;

(2) an Internet-based listing of the state regions, counties, or three-digit ZIP Code areas within the insurer's service area(s), indicating as appropriate for each region, county or ZIP Code area, as applicable, that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) an Internet-based listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of Rights under a Network Plan Required. An insurer is required to include the notice specified in Figure: 28 TAC §3.3705(f) in all policies, certificates, and outlines of coverage in at least 12 point font:
Figure: 28 TAC §3.3705(f)

(g) [~~(e)~~] Untrue or Misleading Information Prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure Concerning Access to Preferred Provider Listing. The insurer is required to provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how a nonelectronic copy of the listing may be obtained and a telephone number through which insureds

may obtain assistance during regular business hours to find available preferred providers.

(i) Required Updates of Available Provider Listings. The insurer is required to ensure that all electronic or nonelectronic listings of preferred providers made available to insureds are updated at least every three months.

(j) Annual Provision of Provider Listing Required in Certain Cases. If no Internet-based preferred provider listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer is required to distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if such alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance Upon Provider Listing in Certain Cases. A claim for services rendered by a nonpreferred provider must be paid at the applicable preferred benefit coinsurance percentage if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional Listing-Specific Disclosure Requirements. In all preferred provider listings, including any Internet-based postings of information made available by the insurer to provide information to insureds about preferred providers, the insurer is required to comply with the requirements in paragraphs (1) - (11) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to:

(A) exercise good faith efforts to accommodate requests from insureds to utilize preferred providers; and

(B) in those instances in which a particular facility-based physician or physician group is assigned at least 48 hours prior to services being rendered, provide the insured with information that is:

*(i)* furnished at least 24 hours prior to services being rendered; and

*(ii)* sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify those hospitals at which more than 10 percent of the dollar amount of total claims filed with the insurer by or on behalf of facility-based physicians other than neonatologists and pathologists are filed by or on behalf of a physician that is not under contract with the insurer.

(3) In determining whether a hospital meets the specifications in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must designate those preferred providers that have notified the insurer of the preferred provider's participation in a regional quality of care peer review program.

(6) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(7) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians able to provide services at preferred provider facilities.

(8) The provider information must be provided in fonts of not less than 10-point type.

(9) The provider information must specifically identify those facilities at which the insurer has no contracts with a type of facility-based provider, specifying the applicable provider type.

(10) The provider information must specifically identify those facilities at which the insurer has a contract or contracts with facility-based providers that have an exclusive contract with the facility, specifying the provider type.

(11) The provider information must specify the date on which the information was provided to the insured.

(m) Annual Policyholder Notice Concerning Use of Access Plan. An insurer operating a preferred provider benefit plan that relies upon an access plan as specified in §3.3709 of this subchapter is required to provide notice of this fact to each individual and group policyholder participating in such plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include a link to any webpage listing of regions, counties, or ZIP Codes made available pursuant to subsection (e)(2) of this section.

(n) Disclosure of Substantial Decrease in the Availability of Certain Preferred Providers. An insurer is required to provide notice of a substantial decrease in the availability of preferred facility-based physicians at a preferred provider facility as specified in this subsection.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice of the termination.

(2) Notwithstanding paragraph (1) of this subsection, no notice is required if alternative preferred providers of the same specialty as the physician group that terminates a contract as specified in

paragraph (1) of this subsection are made available to insureds at the facility such that the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease.

(3) An insurer is required to prominently post notice of the termination specified in paragraph (1) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of the termination specified in paragraph (1) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.

(5) In addition to posting notice as specified in paragraph (3) of this subsection, an insurer is required to update its Internet-based preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures Concerning Reimbursement of Basic Benefit Services. An insurer is required to make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of basic benefit services as specified in this subsection.

(1) An insurer is required to disclose how reimbursements of nonpreferred providers will be determined.

(2) If an insurer reimburses nonpreferred providers based directly or indirectly upon data regarding usual, customary, or reasonable charges by providers, the insurer is required to disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.

(3) If an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer is required to:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method for insureds to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

(p) Plan Designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers) without reliance upon an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this subchapter, the insurer is required to disclose that the plan has a "Limited Hospital Care Network:"

(1) on the cover page of any insurance policy, certificate of coverage, or outline of coverage utilizing the network; and

(2) on the cover page of any nonelectronic provider listing describing the network.

(q) Loss of Status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this subchapter and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer is required to:

(1) notify the department in writing concerning such change in status at Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104;

(2) cease marketing the plan as an AHCN; and

(3) inform all insureds of such change of status at the time of renewal.

~~[(f) A current list of preferred providers shall be distributed to all prospective insureds, and to all insureds no less than annually, and shall be filed with the department by June 1 of each year.]~~

~~[(g) Unless exempted by statute or rule, the insurer shall provide to each insured a toll free number to be maintained 50 hours per week during regular business hours that the insured can call to obtain a current, up-to-date list of preferred providers.]~~

*§3.3706. Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process.*

(a) Access to Designation as a Preferred Provider. Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners, and institutional providers[~~,~~] if such other health care providers are included by an insurer as preferred providers, that are licensed to treat injuries or illnesses or to provide services covered by the preferred provider benefit plan and that comply with the terms and conditions established by the insurer for designation as preferred providers, are [~~shall be~~] eligible to apply for and must be afforded a fair, reasonable and equitable opportunity to become preferred providers, subject to subsection (b) of this section.

(1) An insurer initially sponsoring a preferred provider benefit plan is required to [~~shall~~] notify all physicians and practitioners in the service area covered by the plan of its intent to offer the plan and of the opportunity to apply to participate.

(2) Subsequently, an insurer is required to [~~shall~~] annually notify all non-contracting physicians and practitioners in the service area covered by the plan of the existence of the plan and the opportunity to apply to participate in the plan.

(3) An insurer is required [~~shall~~], upon request, to make available to any physician or provider information concerning the application process and qualification requirements, including the use of economic profiling by the insurer, used by the insurer to admit a provider to the plan.

(4) All notifications required to be made by an insurer pursuant to this subsection are required to [~~shall~~] be made by publication or distributed in writing to each physician and practitioner in the same manner.

(5) Selection standards used by the insurer in choosing participating preferred providers must not directly or indirectly:

(A) avoid high risk populations by excluding physicians or providers because the physicians or providers are located in geographic areas that contain populations presenting a risk of higher than average claims, losses or health services utilization; or

(B) exclude a physician or provider because the physician or provider treats or specializes in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(b) Withholding Preferred Provider Designation. An insurer may not unreasonably withhold designation as a preferred provider except [~~Designation as a preferred provider shall not be unreasonably withheld provided~~] that, unless otherwise limited by the Insurance Code or rule promulgated by the department, an insurer may reject an application from a physician or health care provider on the basis that the preferred provider benefit plan has sufficient qualified providers.

(1) An insurer is required to [~~shall~~] provide written notice of denial of any initial application to a physician or health care provider, which includes:

(A) the specific reason(s) for the denial; and

(B) in the case of physicians and practitioners, the right to a review of the denial as set forth in paragraph (2) of this subsection.

(2) An insurer is required to [~~shall~~] provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel.

(A) The advisory review panel is required to [~~shall~~] be composed of not less than three individuals selected by the insurer from the list of physicians or practitioners in the applicable service area contracting with the insurer.

(B) At least one of the three individuals on the advisory review panel is required to [~~shall~~] be a physician or practitioner in the same or similar specialty as the physician or practitioner requesting review unless there is no physician or practitioner in the same or similar specialty contracting with the insured.

(C) The list of physicians or practitioners required by subparagraph (A) of this paragraph is required to [~~shall~~] be provided to the insurer by the physicians or practitioners who contract with the insurer in the applicable service area.

(D) The recommendation of the advisory review panel is required to [~~shall~~] be provided upon request to the affected physician or practitioner.

(E) In the event that the insurer makes a determination that is contrary to the recommendation of the advisory review panel, a written explanation of the insurer's determination is required to [~~shall~~] be provided to the affected physician or practitioner upon request.

(c) Credentialing of Preferred Providers. Insurers are required to have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. At a minimum, an insurer's credentialing standards are required to meet the standards promulgated by the NCQA or URAC to the extent that those standards do not conflict with other laws of this state. Insurers shall be presumed to be in compliance with statutory and regulatory requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, the American Accreditation HealthCare Commission, the URAC, or the Accreditation Association for Ambulatory Health Care.

(d) [~~(c)~~] Notice of Termination of a Preferred Provider Contract. Before terminating a contract with a preferred provider, the insurer is required to [~~shall~~] provide written notice of termination, which includes:

(1) the specific reason(s) for the termination; and

(2) in the case of physicians or practitioners, notice of the right to request a review prior to termination that is conducted in the same manner as the review mechanism set forth in subsection (b)(2) of this section and that complies with [~~which includes~~] the timelines set forth in subsections (e) - (h) of this section [~~(d) and (e)~~] for requesting review, except in cases involving:

(A) imminent harm to patient health;

(B) an action by a state medical or other physician licensing board or other government agency which impairs the physician's or practitioner's ability to practice medicine or to provide services; or

(C) fraud or malfeasance.

(e) [~~(d)~~] Review of a Decision to Terminate. To obtain a standard review of an insurer's decision to terminate him or her, a physician or practitioner must [~~shall~~]:

(1) make a written request to the insurer for a review of that decision within 10 [~~ten~~] business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 20 business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(f) [~~(3)~~] Completion of the Review Process. The review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, is required to [~~shall~~] be completed and the results provided to the physician or practitioner within 60 calendar days of the insurer's receipt of the request for review.

(g) [~~(e)~~] Expedited Review Process. To obtain an expedited review of an insurer's decision to terminate him or her, a physician or practitioner must [~~shall~~]:

(1) make a written request to the insurer for a review of that decision within five business days of receipt of notification of the insurer's intent to terminate him or her; and

(2) deliver to the insurer, within 10 [~~ten~~] business days of receipt of notification of the insurer's intent to terminate him or her, any relevant documentation the physician or practitioner desires the advisory review panel and insurer to consider in the review process.

(h) [~~(3)~~] Completion of the Expedited Review Process. The expedited review process, including the recommendation of the advisory review panel and the insurer's determination as required by subsection (b)(2)(E) of this section, shall be completed and the results provided to the physician or practitioner within 30 calendar days of the insurer's receipt of the request for review.

(i) [~~(f)~~] Confidentiality of Information Concerning [~~information concerning~~] the Insured [~~insured~~].

(1) An insurer is required to [~~shall~~] preserve the confidentiality of individual medical records and personal information used in its termination review process. Personal information of the insured includes [~~shall include~~], at a minimum, the insured's name, address, telephone number, social security number, and financial information.

(2) An insurer may not disclose or publish individual medical records or other confidential information about an insured without the prior written consent of the insured or unless otherwise required by law. An insurer may provide confidential information to the advisory review panel for the sole purpose of performing its advisory review function. Information provided to the advisory review panel is required to [~~shall~~] remain confidential.

(j) [~~(g)~~] Notice to Insureds [~~insureds~~].

(1) If the contract of a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer may [~~shall~~] not notify insureds of the termination until the effective date of the termination or at such time as an advisory review panel makes a formal recommendation regarding the termination, whichever is later.

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the insurer is required to [~~shall~~] provide assistance to the physician or provider in assuring that the notice requirements are met as required by §3.3703(a)(17) [~~§3.3703(a)(18)~~] of this subchapter [~~title~~] (relating to Contracting Requirements).

(3) If the contract of a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify insureds immediately.

*§3.3707. Waiver Due to Failure to Contract in Local Markets.*

(a) In accordance with the Insurance Code §1301.0055(3), upon a showing by an insurer that providers or physicians necessary for an adequate network in local markets under this subchapter are not available for contracting, have refused to contract with the insurer on any terms, or have sought contract terms that are unreasonable, the department may excuse the insurer from one or more network adequacy requirements in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers) and may impose reasonable conditions on the grant of such waiver.

(b) An insurer seeking a waiver under subsection (a) of this section is required to file the request with the department at the Office of the Chief Clerk, MC 113-2A, P.O. Box 149104, Austin, TX 78714-9104. The insurer is also required to submit a copy of the request to any provider or physician named in the request for waiver at the same time that the request is filed with the department. The insurer may use any reasonable means to submit the copy of the request to the provider or physician and is required to maintain proof of such submission.

(c) Any provider or physician may elect to provide a response to an insurer's request for waiver by filing such response within 30 days after the insurer files the request with the department. Such response, if filed, shall be filed at the same address specified in subsection (b) of this section for filing the request for waiver.

(d) If the department grants a waiver under subsection (a) of this section, the department shall post on the department's website the name of the preferred provider benefit plan for which the request is granted, the insurer offering the plan, and the affected service area.

(e) An insurer is required to apply for renewal of a waiver described in subsection (a) of this section annually and at the same time the insurer files the annual network adequacy report required under §3.3709 of this subchapter (relating to Annual Network Adequacy Report; Access Plan).

(f) An insurer's receipt of a waiver under this section does not authorize the insurer to designate its plan as having an "Approved Hospital Care Network" (AHCN). The insurer is required to designate such plan as having a "Limited Hospital Care Network" in accordance with the requirements of §3.3705(p) of this subchapter (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations).

*§3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver.*

(a) An insurer must comply with the requirements of subsections (b) and (e) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

(1) requiring emergency care;

(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and

(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.

(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to:

(1) pay such claim at the preferred benefit coinsurance level; and

(2) credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for covered services toward the insured's deductible and annual out-of-pocket maximum.

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;

(2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(3) is updated no less than once per year;

(4) does not use data that is more than three years old; and

(5) is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) An insurer is required to pay all covered basic benefits for services obtained from health care providers or physicians at least at the plan's basic benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan shall not be a basis for denial of a claim.

(e) Effective January 1, 2012, when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer is required to include a notice on each explanation of benefits that the insured has the right to request the following information for comparison purposes:

(1) the median per-service amount the insurer has negotiated with preferred providers for the service furnished, excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount;

(2) the amount for the service calculated using the same method the insurer generally uses to determine payments for basic ben-

efits provided by nonpreferred providers (such as the usual, customary, and reasonable amount), excluding any cost sharing imposed with respect to the insured, or notification that the claim was paid at this amount; and

(3) the amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the service, excluding any cost sharing imposed with respect to the insured.

(f) An insurer may apply for a six-month waiver of the requirements of subsection (e) of this section by complying with the requirements specified in paragraphs (1) - (3) of this subsection.

(1) Waiver applications are required to be:

(A) submitted on 8 1/2 by 11 inch paper;

(B) legible;

(C) in typewritten, computer-generated, or printer's proof format; and

(D) signed by an officer of the insurer.

(2) Waiver applications are required to be mailed to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(3) An application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including:

(A) undue hardship, including financial or operational hardship;

(B) the geographical area in which the insurer operates;

(C) the total number of insureds covered by the insurer and the number of insureds impacted by the waiver;

(D) specification of the insurer's plan to achieve compliance with the requirements of subsection (e) of this section, including identification of actions already taken and those planned to be taken; and

(E) the estimated cost of compliance with subsection (e) of this section and an estimate of the increased cost for compliance at an earlier date.

(g) The waiver application is received when the commissioner has received a waiver application containing all specific facts and circumstances as listed in subsection (f) of this section, including any addendums provided by the insurer.

*§3.3709. Annual Network Adequacy Report; Access Plan.*

(a) Network Adequacy Report Required. An insurer is required to file a network adequacy report with the department on or before April 1st of each year and prior to marketing any plan in a new service area.

(b) General Content of Report. The report required in subsection (a) of this section must specify:

(1) the trade name of each preferred provider benefit plan in which insureds currently participate;

(2) the applicable service area of each plan; and

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards set forth in §3.3704 of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers).

(c) Additional Content Applicable Only to Annual Reports. As a part of the annual report on network adequacy, each insurer is required to provide additional demographic data as specified in paragraphs (1) - (6) of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this subchapter (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer is required to specify in the report that there is no applicable data for that region. The report must include the number of:

(1) claims for basic benefits, excluding claims paid at the preferred benefit coinsurance level;

(2) claims for basic benefits that were paid at the preferred benefit coinsurance level;

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for basic benefits or concerning balance billing;

(5) complaints by insureds relating to the availability of preferred providers; and

(6) complaints by insureds relating to the accuracy of preferred provider listings.

(d) Additional Content Applicable if Inadequate Networks are Utilized. As a part of the annual report on network adequacy, an insurer is required to submit a local market access plan as specified in subsection (e) of this section if any of the insurer's preferred provider benefit plans utilize a preferred provider service delivery network that does not comply with the network adequacy requirements specified in §3.3704 of this subchapter.

(e) Content of Local Market Access Plan.

(1) A local market access plan required under subsection (d) of this section must specify for each service area that does not meet the network adequacy requirements:

(A) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this subchapter, including a specification of the type of provider that is not sufficiently available;

(B) a map, with key and scale, that identifies the geographic areas within the service area in which such health care services and/or physicians and providers are not available;

(C) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this subchapter;

(D) procedures that the insurer will utilize to assist insureds to obtain medically necessary services when no preferred provider is reasonably available; and

(E) procedures detailing how basic benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this subchapter (relating to Payment of Certain Basic Benefit Claims and Related Disclosures; Waiver).

(2) The department may request additional information necessary to assess the local market access plan.

(f) Procedures to Supplement Local Market Access Plan. An insurer is required to establish and implement documented procedures as specified in this subsection for use in all service areas for which a

local market access plan is submitted as required in subsection (d) of this section.

(1) The insurer must utilize a documented procedure to:

(A) identify requests for preauthorization of services for insureds that are likely to require, directly or indirectly, the rendition of services by physicians or providers that do not have a contract with the insurer;

(B) furnish to such insureds, prior to such services being rendered, an estimate of the amount the insurer will pay the physician or provider; and

(C) notify the insured that the insured may be liable for any amounts charged by the physician or provider that are not paid in full by the insurer.

(2) The insurer must utilize a documented procedure to:

(A) identify claims filed by nonpreferred providers in instances in which no preferred provider was reasonably available to the insured; and

(B) make initial and, if required, subsequent payment of such claims at the preferred benefit coinsurance level.

(g) Negotiation Procedure Permitted in Access Plan. A local market access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(h) Filing the Report. The annual report required under this section must be submitted electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following e-mail address: hwcn@tdi.state.tx.us.

(i) Access Plan Required if Network Adequacy Status Changes. If the status of a preferred provider service delivery network utilized in any preferred provider benefit plan changes such that the plan no longer complies with the network adequacy requirements specified in §3.3704 of this subchapter for a specific service area, the insurer is required to establish an access plan within 30 days of the date on which the network becomes non-compliant. Such access plan must contain all of the information specified in subsection (e) of this section and must be made available to the department upon request.

*§3.3710. Failure to Provide an Adequate Network.*

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's preferred provider service delivery network and any access plan supporting such network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered pursuant to the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more of the following sanctions pursuant to the authority of the commissioner in the Insurance Code Chapter 83 to issue cease and desist orders:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and/or

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty pursuant to the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

*§3.3711. Geographic Regions.*

The 11 Texas geographic regions that an insurer is permitted to use for purposes of defining a smaller than statewide service area as described in §3.3705(d)(1) of this subchapter (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations) are as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, comprised of the following ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054, 79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110, 79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, comprised of the following ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464, 76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227, 79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;

(3) Region 3--Metroplex, including Fort Worth and Dallas, comprised of the following ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062, 75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138,

75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180, 75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211, 75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001, 76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108, 76109, 76110, 76111, 76112, 76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;

(4) Region 4--Northeast Texas, including Tyler, comprised of the following ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450, 75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637, 75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651, 75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;

(5) Region 5--Southeast Texas, including Beaumont, comprised of the following ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969, 75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664, 77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;

(6) Region 6--Gulf Coast, including Houston and Huntsville, comprised of the following ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255, 77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304, 77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365, 77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583,

77584, 77586, 77587, 77588, 77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;

(7) Region 7--Central Texas, including Austin and Waco, comprised of the following ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539, 76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606, 78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615, 78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721, 78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;

(8) Region 8--South Central Texas, including San Antonio, comprised of the following ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029, 78039, 78050, 78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219, 78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291, 78292, 78293, 78294, 78295, 78296, 78297, 78298, 78299, 78604, 78614, 78618, 78623, 78624, 78629, 78631, 78632, 78638, 78658, 78670, 78671, 78675, 78677, 78801, 78802, 78827, 78828, 78829, 78830, 78832, 78833, 78834, 78836, 78837, 78838, 78839, 78840, 78841, 78842, 78843, 78847, 78850, 78852, 78853, 78860, 78861, 78870, 78871, 78872, 78873, 78877, 78879, 78880, 78881, 78883, 78884, 78885, 78886, and 78959;

(9) Region 9--West Texas, including Midland, Odessa, and San Angelo comprised of the following ZIP Coded areas: 76820, 76825, 76836, 76837, 76841, 76842, 76848, 76849, 76852, 76854, 76855, 76856, 76858, 76859, 76862, 76866, 76869, 76872, 76874, 76886, 76887, 76901, 76902, 76903, 76904, 76905, 76906, 76908, 76909, 76930, 76932, 76933, 76934, 76935, 76936, 76937, 76939, 76940, 76941, 76943, 76945, 76949, 76950, 76951, 76953, 76955, 76957, 76958, 78851, 79331, 79342, 79359, 79360, 79377, 79511, 79701, 79702, 79703, 79704, 79705, 79706, 79707, 79708, 79710, 79711, 79712, 79713, 79714, 79718, 79719, 79720, 79721, 79730, 79731, 79733, 79735, 79738, 79739, 79740, 79741, 79742, 79743, 79744, 79745, 79748, 79749, 79752, 79754, 79755, 79756, 79758, 79759, 79760, 79761, 79762, 79763, 79764, 79765, 79766, 79768, 79769, 79770, 79772, 79776, 79777, 79778, 79780, 79781, 79782, 79783, 79785, 79786, 79788, 79789, and 79848;

(10) Region 10--Far West Texas, including El Paso, comprised of the following ZIP Coded areas: 79734, 79821, 79830, 79831, 79832, 79834, 79835, 79836, 79837, 79838, 79839, 79842, 79843, 79845, 79846, 79847, 79849, 79851, 79852, 79853, 79854, 79855, 79901, 79902, 79903, 79904, 79905, 79906, 79907, 79908, 79910, 79911, 79912, 79913, 79914, 79915, 79916, 79917, 79918, 79920, 79922, 79923, 79924, 79925, 79926, 79927, 79928, 79929, 79930, 79931, 79932, 79934, 79935, 79936, 79937, 79938, 79940, 79941, 79942, 79943, 79944, 79945, 79946, 79947, 79948, 79949, 79950, 79951, 79952, 79953, 79954, 79955, 79958, 79960, 79961, 79968, 79976, 79978, 79980, 79990, 79995, 79996, 79997, 79998, 79999, 88510, 88511, 88512, 88513, 88514, 88515, 88516, 88517, 88518, 88519, 88520, 88521, 88523, 88524, 88525, 88526, 88527, 88528, 88529, 88530, 88531, 88532, 88533, 88534, 88535, 88536, 88538, 88539, 88540, 88541, 88542, 88543, 88544, 88545, 88546, 88547, 88548, 88549, 88550, 88553, 88554, 88555, 88556, 88557, 88558, 88559, 88560, 88561, 88562, 88563, 88565, 88566, 88567, 88568, 88569, 88570, 88571, 88572, 88573, 88574, 88575, 88576, 88577, 88578, 88579, 88580, 88581, 88582, 88583, 88584, 88585, 88586, 88587, 88588, 88589, 88590, and 88595; and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, comprised of the following ZIP Coded areas: 77950, 77990, 78007, 78022, 78040, 78041, 78042, 78043, 78044, 78045, 78046, 78049, 78060, 78067, 78071, 78072, 78075, 78076, 78102, 78104, 78125, 78142, 78145, 78146, 78162, 78330, 78332, 78333, 78335, 78336, 78338, 78339, 78340, 78341, 78342, 78343, 78344, 78347, 78349, 78350, 78351, 78352, 78353, 78355, 78357, 78358, 78359, 78360, 78361, 78362, 78363, 78364, 78368, 78369, 78370, 78371, 78372, 78373, 78374, 78375, 78376, 78377, 78379, 78380, 78381, 78382, 78383, 78384, 78385, 78387, 78389, 78390, 78391, 78393, 78401, 78402, 78403, 78404, 78405, 78406, 78407, 78408, 78409, 78410, 78411, 78412, 78413, 78414, 78415, 78416, 78417, 78418, 78419, 78426, 78427, 78460, 78461, 78463, 78465, 78466, 78467, 78468, 78469, 78470, 78471, 78472, 78473, 78474, 78475, 78476, 78477, 78478, 78480, 78501, 78502, 78503, 78504,

78505, 78516, 78520, 78521, 78522, 78523, 78526, 78535, 78536, 78537, 78538, 78539, 78540, 78541, 78543, 78545, 78547, 78548, 78549, 78550, 78551, 78552, 78553, 78557, 78558, 78559, 78560, 78561, 78562, 78563, 78564, 78565, 78566, 78567, 78568, 78569, 78570, 78572, 78573, 78574, 78575, 78576, 78577, 78578, 78579, 78580, 78582, 78583, 78584, 78585, 78586, 78588, 78589, 78590, 78591, 78592, 78593, 78594, 78595, 78596, 78597, 78598, and 78599.

*§3.3712. Facility-Based Physician Disclosure of Certain Billed Charges.*

The billed charges for professional services that an insurer must require to be publicly disclosed pursuant to §3.3703(a)(26)(B)(i) of this subchapter (relating to Contracting Requirements) are as follows:

(1) General Professional Services - CPT Codes 58140, 58150, 58180, 58260, 58550, 58552, 59025, 59400, 59510, 90657, 90658, 90669, 90700, 90707, 90713, 90716, 90718, 90744, 90746, 90806, 92004, 92014, 93000, 93307, 93307*26, 93510, 93510*26, 95004, 95117, 95165, 96372, 96413, 97140, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99391, 99392, 99393, 99394, 99395, 99396, 99397;

(2) Pathology - CPT Codes 80048, 80053, 80061, 81000, 81025, 82270, 82947, 82962, 84153, 84443, 85018, 85025, 85610, 87491, 87880, 88142, 88304, 88304*26, 88305, 88305*26, 88307, 88307*26, 88309, 88309*26, 88312, 88331, 88331*26, 88342, 88342*26;

(3) Anesthesiology - CPT Codes 00142, 00160, 00300, 00320, 00400, 00630, 00670, 00740, 00790, 00810, 00840, 00944, 01400, 01402, 01480, 01630, 01810, 01961, 01967, 01992;

(4) Radiology - CPT Codes G0202, G0202*26, G0204, G0204*26, G0206, G0206*26, 70450, 70450*26, 70460, 70460*26, 70470, 70470*26, 70486, 70486*26, 70487, 70487*26, 70488, 70488*26, 70498, 70498*26, 70543, 70543*26, 70544, 70544*26, 70549, 70549*26, 70551, 70551*26, 70552, 70552*26, 70553, 70553*26, 71010, 71010*26, 71020, 71020*26, 71250, 71250*26, 71260, 71260*26, 71270, 71270*26, 71275, 71275*26, 72131, 72131*26, 72132, 72132*26, 72133, 72133*26, 72141, 72141*26, 72146, 72146*26, 72148, 72148*26, 72156, 72156*26, 72157, 72157*26, 72158, 72158*26, 72191, 72191*26, 72192, 72192*26, 72193, 72193*26, 72195, 72195*26, 72197, 72197*26, 73090, 73090*26, 73120, 73120*26, 73130, 73130*26, 73206, 73206*26, 73218, 73218*26, 73220, 73220*26, 73221, 73221*26, 73222, 73222*26, 73223, 73223*26, 73510, 73510*26, 73520, 73520*26, 73550, 73550*26, 73560, 73560*26, 73564, 73564*26, 73565, 73565*26, 73600, 73600*26, 73610, 73610*26, 73620, 73620*26, 73630, 73630*26, 73700, 73701, 73701*26, 73702, 73702*26, 73706, 73706*26, 73718, 73718*26, 73720, 73720*26, 73721, 73721*26, 73723, 73723*26, 74000, 74000*26, 74022, 74022*26, 74150, 74150*26, 74160, 74160*26, 74170, 74170*26, 74175, 74175*26, 74181, 74181*26, 74183, 74183*26, 74241, 74241*26, 76645, 76645*26, 76700, 76700*26, 76801, 76801*26, 76805, 76805*26, 76817, 76817*26, 76830, 76830*26, 76856, 76856*26, 77051, 77051*26, 77052, 77052*26, 77055, 77055*26, 77056, 77056*26, 77057, 77057*26, 77078, 77078*26, 77080, 77080*26, 77081, 77081*26, 77082, 77082*26, 77418, 77427, 78814, 78814*26, 78815, 78815*26, 78816, 78816*26;

(5) Neonatology Critical Care/Newborn Care - CPT Codes 99460, 99461, 99462, 99463, 99464, 99465, 99468, 99469, 99478, 99479, 99480; and

(6) Professional Services (Outpatient) - CPT Codes 19102, 19103, 19120, 29824, 29826, 29827, 29877, 29879, 29880, 29881, 29888, 31255, 36561, 42820, 43234, 43235, 43239, 45378, 45380, 45384, 45385, 47000, 49505, 52332, 58558, 58563, 58661, 58662, 62311, 64721, 66984, 69436.

*§3.3713. Submission and Disclosure of Information Concerning the Effects of Uncompensated Care; Waiver.*

(a) Effective seven years from the effective date of this section, an insurer is required to submit to the department on the first business day of each July the following information concerning the effects of uncompensated care:

(1) whether the contracted charges for each preferred provider facility reflect the facility's cost of uncompensated care; and

(2) a financial analysis of the monetary impact of uncompensated care on the contracted charges of each contracted facility.

(b) The information concerning the effects of uncompensated care are required to be submitted to the department electronically in a format acceptable to the department. Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following e-mail address: lhlmail@tdi.state.tx.us.

(c) Effective eight years from effective date of this section, an insurer is required to make the information concerning the effects of uncompensated care as reported to the department publicly available and provide notice of the availability of such information in each policy, certificate, and outline of coverage.

(d) An insurer's contract with a facility must contain provisions permitting the insurer to obtain information from the facility necessary to complete the financial analysis required by this section.

(e) An insurer may apply for a six-month waiver from some or all of the requirements of this section by complying with paragraphs (1) - (3) of this subsection.

(1) Waiver applications are required to be:

(A) submitted on 8 1/2 by 11 inch paper;

(B) legible;

(C) in typewritten, computer-generated, or printer's proof format; and

(D) signed by an officer of the insurer.

(2) Waiver applications are required to be mailed to: Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(3) An application for a full or partial waiver is required to provide specific facts and circumstances that justify a waiver, including:

(A) undue hardship, including financial or operational hardship;

(B) the geographical area in which the insurer operates;

(C) the total number of insureds covered by the insurer and the number of insureds impacted by the waiver;

(D) specification of the insurer's plan to achieve compliance with the requirements of subsections (a) - (d) of this section, including identification of actions already taken and those planned to be taken; and

(E) the estimated cost of compliance with subsections (a) - (d) of this section and an estimate of the increased cost for compliance at an earlier date.

(f) The waiver application is received when the commissioner has received a waiver application containing all specific facts and circumstances as listed in subsection (e) of this section, including any addendums provided by the insurer.

(g) The commissioner may impose reasonable conditions upon the grant of a waiver under this section.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100170
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: February 27, 2011
For further information, please call: (512) 463-6327

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# PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

## CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

## SUBCHAPTER I. MEDICAL BILL REPORTING

**28 TAC §§134.800 - 134.808**

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) proposes amendments to §134.802 and the addition of §§134.800, 134.801, 134.803, 134.804, 134.805, 134.806, 134.807, and 134.808 concerning insurance carrier medical electronic data interchange (EDI) reporting to the Division. The amendment and additions are necessary to improve insurance carrier understanding of the business and technical requirements associated with reporting medical charge and payment data as required by statutory provisions of Labor Code §413.007 and §413.008. The amendment and additions codify the existing data reporting requirements, with minimal changes to the current technical infrastructure associated with medical EDI reporting.

Senate Bill (SB) 1, enacted by the 71st Legislature, Second Called Session, effective January 1, 1991, amended Vernon's Annotated Civil Statutes by adding new §8308-8.01 and §8308-8.04 (later codified as Labor Code §413.007 and §413.008). These provisions required the Division to maintain a statewide data base of medical charges, actual payments, and treatment protocols to be used in adopting and administering medical policies and fee guidelines. In addition, these provisions required insurance carriers to provide specific information regarding health care treatment, services, fees, and charges. In response to this statutory requirement, the Texas Workers' Compensation Commission (Commission), the predecessor of the Texas Department of Insurance, Division of Workers' Compensation, adopted §134.802, effective February 20, 1991, which required insurance carriers to submit paper copies of professional and institutional medical bills to the agency. The Commission later amended this rule to require the electronic submission of the data contained on these medical bills, effective January 1, 1993. The medical bill and payment data was submitted to the Commission using a format developed by agency staff, which did not support the submission of dental or pharmacy medical bills. After the International Association of Industrial Accident Boards and Commissions (IAIABC) published an implementation guide for reporting this data in a standardized format, the Commission revised these rules to require the reporting of all types of medical bills on and after January 1, 2005. Concurrent with these changes, the agency modified the technical requirements associated with the submission of this data following the *IAIABC EDI Implementation Guide for Medical Bill Payment Records,* Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide).

In order to communicate the more detailed technical requirements associated with these EDI submissions, the agency published extensive implementation guides, which were modified on various occasions. These external documents occasionally contained typographical errors or other information that created some confusion regarding the reporting requirements. In reviewing the data submitted by insurance carriers over the last few years, the Division has identified several issues that impact the accuracy and timeliness of reporting. Accordingly, these proposed rules present the requirements in a more concrete and understandable format, which should improve the ability of insurance carriers to comply with the regulatory requirements and eliminate the reliance on the more difficult to understand implementation guides. The restructuring of these rules will improve the ability of the Division to make future amendments to medical billing and coding requirements by allowing the Division to revise adoption of reference material as opposed to modifying extensive implementation guides where certain requirements may be repeated in various sections. Lastly, these proposed rules add some additional requirements to improve data quality, such as the submission of the health care provider identification numbers at the line level on professional medical bills.

As part of the development process for these proposed rules, the Division posted an informal working draft of the sections on its website on November 10, 2010 and received 18 written informal comments from system participants. These proposed rules incorporate several recommendations offered by those system participants.

Other amendments are proposed throughout the rule text to correct typographical, grammatical, and punctuation errors in the current rule text, make changes to conform rule text to current drafting style, and simplify and clarify provisions in Chapter 134.

Proposed new §134.800: The proposed new §134.800 clarifies that the subchapter applies to all insurance carriers as defined in Labor Code §401.011(27), and requires all insurance carriers to report information prescribed by the commissioner for each medical bill on a workers' compensation claim. The term insurance carrier is defined by Labor Code §401.011(27) and means insurance companies, certified self-insurers, certified self-insured groups, and governmental entities that self-insure. Additional language in this subsection clarifies that insurance carriers that have contracted with or established a workers' compensation health care network and insurance carriers that provide medical benefits in a manner authorized by Labor Code §504.053(b)(2) retain the responsibility of data reporting. This proposed section is important for the future scalability of the rules, in the event that

other subsections are added that impact the applicability to various entities or timeframes. The proposed new §134.800(b) provides for an effective date of July 1, 2011, affording insurance carriers sufficient time to make the minor modifications necessary to ensure compliance. This provision also allows insurance carriers and trading partners to complete testing and move automated system changes into production prior to the effective date, provided the automated system changes comply with the requirements contained in the proposed subchapter. Prior to the July 1, 2011 effective date, the insurance carriers are required to continue to apply the current rules.

Proposed new §134.801: The proposed new §134.801 clarifies that the purpose of the subchapter is to prescribe the reporting requirements for the information and data to be submitted to the Division concerning workers' compensation medical charges and payments and adopts by reference the implementation guide and specifications necessary for successful electronic data interchange transaction processing. The addition of this proposed section is important for the relationship between the provisions of Labor Code §413.007, which requires the Division to maintain a statewide data base of medical data, and the provisions of Labor Code §413.008, which allows the Division to require the submission of this type of data.

Proposed amendment of §134.802: The proposed amendment to §134.802 replaces existing requirements that are contained in other proposed rules with definitions for specific terms used in this subchapter. The use of specific terms within this subchapter makes it important to define the meanings of those terms. The most significant change with these definitions from the current Texas Medical EDI Implementation Guide relates to the term "trading partner," recognizing that an insurance carrier may send the data to the Division directly or may contract with an external entity to fulfill its data reporting requirements.

Proposed new §134.803: The proposed new §134.803(a) specifically adopts by reference the *IAIABC EDI Implementation Guide for Medical Bill Payment Records,* Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide) and clarifies that exceptions are included in the subchapter.

The proposed new §134.803(b) specifically adopts by reference three different tables published by the Division that must be used in conjunction with the IAIABC EDI Implementation Guide in order to successfully transmit Medical EDI Records to the Division. The IAIABC EDI Implementation Guide is structured to allow individual jurisdictions to tailor certain data usage descriptions to their regulatory requirements. As noted in the IAIABC EDI Implementation Guide, this is primarily conveyed through the jurisdiction's publication of a data element requirement and edit table.

The first table is the proposed data element requirement table which outlines the data elements that are required to be submitted to the Division, including the situational rules for conditional data elements. While there are several clerical and grammatical changes related to the situational rules contained on the proposed table as compared with the previously published table, there are three changes that are more substantive in nature. First, the proposed table requires the jurisdiction claim number when the insurance carrier has received the Division claim number. The jurisdictional claim number was previously identified on the table as an optional data element, but required when known by the insurance carrier. This change corrects this typographical error and clarifies the reporting requirement in order to improve data matching between the medical billing data base and the claims data base. Second, the proposed table requires rendering line provider's identification numbers when included on the medical bill. The rendering line provider's identification numbers were previously identified on the table as optional data elements, but are needed to improve the accuracy of identifying the health care practitioner that delivered the service to the injured employee. Lastly, the proposed table requires the HCPCS modifier billed code when included on the medical bill. The HCPCS modifier billed code was previously identified on the table as an optional data element, but is needed to improve the accuracy of identifying the service that was performed or determining the appropriate reimbursement rate.

The second table is the proposed edit table which informs insurance carriers about the edits that may be performed on certain data elements. Medical EDI records that do not meet these edits may result in the rejection of specific transactions. The primary changes contained in the proposed table as compared with the previously published table include the removal of the technical language regarding the edits performed by the Division and the inclusion of certain data format requirements that could result in rejections. Over the last couple of years, certain trading partners have questioned whether or not data is accurately submitted based on the technical edit language as opposed to the information contained in the data element requirement table. The edit table is designed to assist insurance carriers and trading partners with understanding why certain data elements may be rejected, but edits may not be applied to all the conditions related to the required or situational data elements. These revisions align the table with the template contained in the IAIABC Implementation Guide and will assist in avoiding this improper interpretation of edits.

The final proposed table that is contained in this subsection is the proposed difference table. The manner in which the Division implemented the IAIABC Implementation Guide framework differs in certain respects. The difference table outlines those technical differences for programming purposes, such as the requirement to submit durable medical equipment data in the SV1 segment as opposed to the SV5 segment.

The proposed new §134.803(c) provides directions on how to obtain copies of the adopted standards. These provisions are included in the rule consistent with the requirements contained in 1 Texas Administrative Code §91.40 (relating to How to File Adoption by Reference (ABR) Material). The proposed new §134.803(d) provides that the provisions of the Labor Code and Division rules prevail in the event of any conflict with the contents of the IAIABC EDI Implementation Guide.

Proposed new §134.804: The proposed new §134.804(a), (b) and (c) set forth the reporting requirements for original medical EDI records and for cancellation and replacement medical EDI records. This proposed section includes information that is currently contained within the Texas Medical EDI Implementation Guide, but presents the information in an easier to understand format. For example, some trading partners have inappropriately reused unique bill identification numbers contrary to the manner in which the Division expected to receive that data element. Including additional information within the context of the rule removes any potential ambiguity regarding the events, the time frames, and the use of this identification number.

The proposed new §134.804(d) requires that insurance carriers timely and accurately submit medical EDI records and lists the conditions necessary for a record to be considered accurate. The proposed new §134.804(e) sets forth the requirement for correcting and resubmitting previously rejected medical EDI

records, including the requirement to use the same unique bill identification number.

Proposed new §134.805: The proposed new §134.805(a) identifies the triggering events that require an insurance carrier to submit a medical EDI record.

The proposed new §134.805(b) outlines additional conditions that must be met in order for a medical EDI record to be timely received. This subsection is intended to inform insurance carriers about the required accuracy requirements and addresses certain data elements that cannot be validated through technical edits and may result in an accepted record during incoming transaction processing. Division reviews on various medical EDI transactions have previously revealed situations where the insurance carrier or their trading partner sent data that was not contained on a medical bill or the associated explanation of benefits, either by manipulation, translation, or omission. The addition of this section clarifies that the data required to be submitted to the Division must reflect the actual data contained on the medical bill and explanation of benefits, as opposed to derived or modified data.

The proposed new §134.805(c) provides that rejected medical EDI records are not considered received and must be corrected and resubmitted within the time frame required by proposed new §134.804(e). Lastly, this new subsection clarifies that medical EDI records submitted in the test environment are not considered received, regardless of whether the records were accepted or rejected.

Proposed new §134.806: The proposed new §134.806 identifies the types of records that are not required to be reported under the subchapter. Due to the nature of the information submitted in these types of medical bills or other reimbursement requests, it is not reasonable to expect an insurance carrier to be able to successfully transmit medical EDI records for these records. While the current Texas Medical EDI Implementation Guide contains exclusions for out-of-country medical services and pre-1991 dates of injuries, it is silent regarding the other transactions resulting in multiple questions from trading partners regarding how to successfully transmit the required data in those situations. It is noted that the current Texas Medical EDI Implementation Guide also excludes denials related to duplicate medical bill submissions, but this exclusion is specifically not contained in the proposed new subsection and these events will be required to be reported.

Proposed new §134.807: The proposed new §134.807(a) - (e) identifies Texas specific technical requirements related to the submission of medical EDI transmissions. The majority of these technical requirements are identical to the information contained in the current Texas Medical EDI Implementation Guide. Additional Texas specific requirements have also been added in proposed §134.807 that are not contained in the current Texas Medical EDI Implementation Guide, including a prohibition against mixed-bill reporting and instructions on pharmacy-related medical bills.

Proposed new §134.808: The proposed new §134.808(a) provides that insurance carriers may contract with trading partners to submit required medical EDI records to the Division.

The proposed new §134.808(b) requires each insurance carrier to designate an EDI compliance coordinator to serve as the central compliance control contact for data reporting. The insurance carrier's EDI compliance coordinator must be a centrally-located employee of the insurance carrier and the insurance carrier cannot delegate this responsibility to an external entity, such as a trading partner.

The proposed new §134.808(c) outlines the processes involved of informing the Division about who will send data on behalf of an insurance carrier, whether it is the insurance carrier or a trading partner. This subsection outlines the requirements to be contained in the notice, including the signature of the insurance carrier's EDI compliance coordinator.

The proposed new §134.808(d) outlines the processes involved for informing the Division about an insurance carrier's or trading partner's EDI profile. This information is used by the Division to set up the technical infrastructure to allow an entity to submit medical EDI transmissions and must be completed before the entity will be able to connect and test their medical EDI records.

The proposed new §134.808(e) outlines the requirements related to testing before an insurance carrier or trading partner will be approved for production submissions.

The proposed new §134.808(f) explicitly states that insurance carriers are responsible for the acts or omissions of their trading partners and that an insurance carrier commits an administrative violation if its trading partner fails to timely or accurately submit medical EDI records.

Mr. Matthew Zurek, Executive Deputy Commissioner of Health Care Management and Systems Monitoring, anticipates that for each year of the first five years the proposed new and amended sections will be in effect, there will be minimal fiscal implication for state government as a result of enforcing or administering the proposed amendments and new rules and there will be no fiscal implications for local governments as a result of enforcing or administering the proposed amendments and new rules because they do not enforce or administer the rule.

The Division may incur minimal costs associated with the preparation of training materials, presentations for system participants, and monitoring the activities of entities related to the implementation of these provisions.

Local and state government entities, when acting in the capacity of an insurance carrier, will be impacted in the same manner as other insurance carriers that are required to comply with the proposed amendments and new rule, as described later in this preamble.

There will be no measurable effect on local employment or the local economy as a result of this proposal.

Mr. Zurek also anticipates that for each year of the first five years the sections are in effect, the anticipated public benefit will be an increase in the accuracy of data available for Division analysis related to the adoption of medical fee guidelines and other regulatory activities. Medical EDI data is heavily used by the Division for multiple administrative and regulatory activities, including the development of medical fee guidelines; system monitoring and research activities under Labor Code Chapter 405; the administration of the Division's Performance Based Oversight (PBO) activities under Labor Code Chapter 402; and the administration of medical quality reviews under Labor Code Chapter 413. The accuracy of the data impacts whether or not individual records can be included in these analyses. For example, in the development of the inpatient and outpatient hospital fee guidelines, the Division provided medical EDI data to Milliman Consultants and Actuaries in order to index workers' compensation facility reimbursement to Medicare facility reimbursement. Due to data anomalies and irregularities in the Division's data, 19.5% of the

inpatient medical EDI records and 45.6% of the outpatient medical EDI records were excluded from the analysis. The additional requirement specification contained in the proposed new and amended sections should greatly improve the usefulness of the data and reduce this level of exclusion in future analyses. In addition, the improvements to the quality of data will help ensure that analyses performed by external entities, including the Workers' Compensation Research Institute, will be useful in making recommendations for policy or system enhancements and changes.

Insurance carriers and trading partners will experience some cost in the modification of automated system to report the jurisdiction claim number, the rendering line provider identification numbers, and the HCPCS modifiers. While many insurance carriers and trading partners already report the HCPCS modifiers, the majority do not report all these new data elements and changes will be necessary to their databases and automated systems. Division records show that there are 89 insurance carriers and trading partners currently submitting medical EDI records to the Division. Each of these entities will need to initiate an automation project to design the changes, modify their existing data base, modify the extract, transform and load processes, and test the changes prior to implementation. It is estimated that this type of automation project will require approximately 60 hours of work. According to the Wage Information Network available from the Labor Market and Career Information of the Texas Workforce Commission, computer programmers receive a median wage of $34.78 per hour. The cost to implement these automation changes equates to 89 (insurance carriers and trading partners) multiplied by $2,087 (60 hours times $34.78), or $185,725.

Certain insurance carriers and trading partners may experience cost related to the modification of the manner in which the unique bill identification number is assigned to the medical EDI records. Conversations with insurance carriers and trading partners revealed that some append the unique bill identification number contained in their system with an additional suffix that is automatically generated when an out-bound file is created. Given the requirement to use the same unique bill identification number on corrected medical EDI records, these insurance carriers and trading partners will need to modify their databases and automated systems to store each unique bill identification number per medical bill per transaction. Based on discussions with various insurance carriers, trading partners, and members of the IAIABC EDI Medical Committee, the Division estimates that approximately 15% of insurance carriers and trading partners will need to make these automation changes. The level of automation changes associated with this requirement is similar to the changes to add the previously mentioned data elements, or approximately 60 hours of programming time, including development and testing. According to the Wage Information Network available from the Labor Market and Career Information of the Texas Workforce Commission, computer programmers receive a median wage of $34.78 per hour. The cost to implement these automation changes equates to 13 (impacted insurance carriers and trading partners) multiplied by $2,087 (60 hours times $34.78), or $27,128.

Insurance carriers and trading partners that have not implemented systems that comply with the current Texas Medical EDI Implementation Guide will experience additional programming and development costs, but those changes are not related to the requirements contained in the proposed amendments and new sections.

In addition, insurance carriers that have contracts with agents, such as pharmacy benefit management (PBM) companies, will be required to review and potentially revise their contracts with these agents regarding the reporting the net amount paid to a pharmacy or the pharmacy's processing agent on an individual medical bill, rather than reporting to the Division the amount paid by the insurance carrier to its agent. This will allow the Division to collect the data needed to ensure that the development of fee guidelines consider "actual payments" to health care providers, are "fair and reasonable and designed to ensure the quality of medical care and to achieve effective cost control." Insurance carriers and trading partners with these relationships will need to modify their systems to capture and report the net amount actually paid to the pharmacies. According to the Wage Information Network available from the Labor Market and Career Information of the Texas Workforce Commission, paralegals and legal assistants receive a median wage of $22.21 per hour, lawyers receive a median wage of $54.53 per hour, and computer programmers receive a median wage of $34.78 per hour. In Fiscal Year 2010, approximately seven trading partners submitted pharmacy medical bills as their primary service types for 225 insurance carrier entities. Assuming these trading partners are pharmacy benefit management companies or similar entities, it is estimated that at least 225 contracts may need to be reviewed and revised. It is estimated that the cost of initial compliance with the pharmacy related changes would be the total of the contract amendment process plus the total for automation changes. The contract amendment process is estimated to require at least 20 hours of paralegal or legal assistant work and eight hours of attorney work per contract. This amount equates to 225 (insurance carrier contracts) multiplied by the sum of $444.20 (20 hours times $22.21) and $436.24 (eight hours times $54.53), or $198,099. The changes to the automated systems are estimated to require approximately 24 hours of programming time, including development and testing. This amount equates to five (trading partners) multiplied by $834.72 (24 hours times $34.78), or $4,174. Accordingly, it is estimated that the costs of the changes to pharmacy reporting would equate to the sum of $198,099 (contract changes) and $4,173.60 (automation changes), or $202,273.

Finally, the modifications to the notice requirements related to the insurance carrier EDI coordinator and other trading partner relationship notification will introduce a new business process for insurance carriers. Since insurance carriers have a similar requirement related to the Texas Detailed Claim Information Statistical Plan, it is not anticipated that any insurance carrier would need to hire additional staff to perform similar functions related to medical EDI reporting. However, the new forms and processes will require staff time to complete the required paperwork and associated retention or validation activities. Each individual insurance carrier will be required to complete and submit the new forms shortly after adoption. It is estimated that the completion of these forms will require approximately four hours of staff time, including research regarding existing relationships and documenting current relationships. It is assumed that an insurance adjuster will likely be assigned to perform these types of activities, due to the detailed knowledge that may be needed related to the business activities of claims management. According to the Wage Information Network available from the Labor Market and Career Information of the Texas Workforce Commission, claims adjusters receive a median wage of $26.29 per hour. In Fiscal Year 2010, medical EDI records were submitted for 725 unique insurance carrier entities. Accordingly, it is estimated that the cost of initial compliance with the notice provisions would be

725 (insurance carriers) multiplied by four (hours) multiplied by $26.29 (median wage), or $76,241.

COST SUMMARY

In summary, during the first year after adoption, it is estimated that the aggregate costs for insurance carriers and trading partners to implement the new requirements would be approximately $491,367. Additional costs are not anticipated after implementation and any costs in subsequent fiscal years would be restricted to standard system maintenance and notification processes.

General Economic Impact Statement

In accordance with the Government Code §2006.002(c), the Division has determined that this proposal may have an adverse economic effect on certain small businesses and micro businesses. In order to perform this analysis, the Division compared the list of 89 insurance carriers and trading partners submitting medical EDI records with the data available from the Standardized Occupational Components for Research and Analysis of Trends in the Employment System (SOCRATES) from the Texas Workforce Commission containing data updated through March 2010. Based on this analysis, three trading partners were identified as meeting the criteria as micro businesses and two trading partners were identified as meeting the criteria for small businesses. The adverse impact is basically driven by the low number of client companies for which these entities provide medical EDI transaction processing and submission. Given the lower customer base, it will likely be more difficult for these businesses to spread any development and deployment costs in a manner which would mitigate potential financial impact. However, it is noted that these businesses choose to offer these services to insurance carriers and none are mandated to comply with these requirements if they choose to no longer participate in medical EDI transaction processing.

The Division also considered not adopting the proposed amendments, implementing different requirements or standards for the affected small and micro-businesses, and exempting the requirements of the proposed amendments and new sections.

*Not adopting the proposed amendments and new sections.* The Division rejected this approach because the current regulatory framework already requires the reporting of this data consistent with the requirements of Labor Code §413.007, which requires the Division to maintain a statewide data base of medical charges, actual payments, and treatment protocols. The proposed changes clarify the data reporting requirements in order to improve the quality of the data, as opposed to imposing new reporting requirements.

*Implementing different requirements or standards for the affected small or micro-businesses.* The Division rejected this option because implementing different requirements or standards would require the development and deployment of different automated systems to handle less than two percent of the number of transactions submitted to the agency. In fiscal year 2010, the Division received 4,830,355 medical EDI records from all trading partners, of which 125,075 were submitted by trading partners meeting the criteria for classification as a small or micro-business. Creating new automated systems and databases for approximately 2.6% of the transaction volume is not fiscally responsible for the agency.

*Exempting small and micro-businesses from the requirements of the proposed amendments and new sections.* The Division rejected this option because these businesses choose to participate in electronic data interchange as a mechanism to secure new business and sustain existing business. The reporting requirement is primarily on the insurance carriers, not the trading partners, which are generally not small or micro-businesses. Exempting these entities from the proposed amendments and new sections would result in inaccurate and incomplete data, which eliminates the ability of the Division to meet the statutory obligation to maintain a statewide database.

The Division has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under Texas Government Code §2007.043.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. CST on February 28, 2011. Comments may be submitted via the internet through the Division's internet website at *http://www.tdi.state.tx.us/wc/rules/proposedrules/index.html,* by email at *rulecomments@tdi.state.tx.us* or by mailing or delivering your comments to Maria Jimenez, Texas Department of Insurance, Division of Workers' Compensation, Workers' Compensation Counsel, MS-4D, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645.

Any request for a public hearing must be submitted separately to the Texas Department of Insurance, Division of Workers' Compensation, Workers' Compensation Counsel, MS-1, 7551 Metro Center Drive, Austin, Texas 78744 by 5:00 p.m. CST by the close of the comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

The amendments and new sections are proposed under the Labor Code §§402.00111, 402.061, 402.075, 405.0025, 413.007, 413.008, 413.011, 413.0511 and 413.0512. Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §413.007 requires the Commissioner of Workers' Compensation to maintain a statewide data base of medical charges, actual payments, and treatment protocols to be used in adopting and administering medical policies and fee guidelines. Labor Code §413.008 requires insurance carriers to provide specific information to the Division regarding health care treatment, services, fees, and charges.

Labor Code §402.075 requires the Commissioner of Workers' Compensation to biennially assess the performance of insurance carriers and health care providers in meeting key regulatory goals. Labor Code §405.0025 requires the Workers' Compensation Research and Evaluation Group to conduct professional studies on the quality and cost of medical benefits and to produce a biennial report on the impact of certified networks.

Labor Code §413.011 requires the Commissioner of Workers' Compensation to adopt health care reimbursement policies and guidelines that must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Labor Code §413.0511 and §413.0512 requires the Division's Medical Advisor and Medical Quality Review Panel to monitor the quality of health care and recommend appropriate

actions regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organizations.

The following statutes are affected by this proposal: §§134.800 - 134.808, Labor Code §§413.002, 413.007 and 413.008.

*§134.800. Applicability.*

(a) This subchapter applies to all insurance carriers as defined in Labor Code §401.011(27), including insurance carriers that have contracted with or established a workers' compensation health care network as defined in Labor Code §401.011(31-a) and insurance carriers that provide medical benefits in a manner authorized by Labor Code §504.053(b)(2). All insurance carriers are required to report information prescribed by the commissioner under Labor Code §413.007 and §413.008 for each medical bill on a workers' compensation claim.

(b) This subchapter becomes effective on July 1, 2011. Insurance carriers and trading partners may submit medical EDI records in accordance with this subchapter prior to this effective date.

*§134.801. Purpose.*

The purpose of this subchapter is to prescribe the reporting requirements for information and data submitted to the division and to adopt by reference the implementation guide and specifications necessary for successful electronic data interchange transaction processing. The reporting of information and data is necessary to maintain a statewide data base of medical charges, actual payments, and treatment protocols pursuant to Labor Code §413.007 and §413.008.

*§134.802. Definitions [~~Insurance Carrier Medical Electronic Data Interchange to the Division~~].*

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(1) Division--The Texas Department of Insurance, Division of Workers' Compensation or its data collection agent.

(2) EDI--Electronic data interchange.

(3) Medical EDI Record--The data associated with a single medical bill which is being reported in a Medical EDI Transaction.

(4) Medical EDI Transmission--The data that is contained within the interchange envelope.

(5) Medical EDI Transaction--The data that is contained within the functional group.

(6) Person--An individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity. This term does not include an injured employee.

(7) Trading Partner--A person that has entered into an agreement with the insurance carrier to format electronic data for transmission to the division, transmits electronic data to the division, and responds to any technical issues related to the contents or structure of an EDI file.

~~[(a) The insurance carrier shall submit medical bill and payment data to the Division within 30 days after the insurance carrier makes payment, denies payment, or receives a refund of overpayment on a medical bill.]~~

~~[(b) Insurance carriers shall submit medical bill and payment data electronically in the form and format prescribed by the Division.~~

~~[(c) The Division shall prescribe the form, format, and content of the required medical bill and payment data submission.]~~

~~[(d) This section shall apply to all dates of service on or after July 15, 2000, for facility and professional medical services except pharmacy and dental services.]~~

~~[(e) This section shall apply to all dates of service on or after January 1, 2005, for pharmacy and dental services in addition to the already required facility and professional medical services.]~~

*§134.803. Reporting Standards.*

(a) Except as provided in this subchapter, the commissioner adopts by reference the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002 (IAIABC EDI Implementation Guide) published by the International Association of Industrial Accident Boards and Commissions (IAIABC).

(b) The commissioner adopts by reference the Texas EDI Medical Data Element Requirement Table, Version 1.0, dated December 2010, the Texas EDI Medical Data Element Edits Table, Version 1.0, dated December 2010, and the Texas EDI Medical Difference Table, Version 1.0, dated December 2010. All tables are published by the division.

(c) Information on how to obtain or inspect copies of the IAIABC EDI Implementation Guide and the adopted division tables may be found on the division's website: http://www.tdi.state.tx.us/wc/indexwc.html.

(d) In the event of a conflict between the IAIABC EDI Implementation Guide and the Labor Code or division rules, the Labor Code or division rules shall prevail.

*§134.804. Reporting Requirements.*

(a) Insurance carriers shall submit an '00' original medical EDI record for each action (initial processing, request for reconsideration, or subsequent orders) taken on an individual medical bill. Original medical EDI records shall be reported within 30 days after the date of the action. Each iteration of an '00' original medical EDI record must contain a different unique medical bill identification number. The amount paid on each action related to a medical bill must contain only the amount issued for that event and must not contain a cumulative amount reflecting all events related to an individual medical bill.

(b) Insurance carriers shall submit an '01' cancel medical EDI record if the '00' original medical EDI record should not have been sent or contained the incorrect insurance carrier identification number. Cancel medical EDI records shall be reported within 30 days after the earliest date the insurance carrier discovered the reporting error. The '01' cancel medical EDI record must contain the same unique bill identification number as the '00' original medical EDI record that was previously submitted and accepted.

(c) Insurance carriers shall submit an '05' replacement medical EDI record when correcting data on a previously submitted medical EDI record. Replacement medical EDI records shall be submitted within 30 days after the earliest date the insurance carrier discovered the reporting error. The '05' replacement medical EDI record must contain the same unique bill identification number as the associated '00' original medical EDI record.

(d) Insurance carriers are responsible for the timely and accurate submission of medical EDI records. For the purpose of this section, a medical EDI record is considered to have been accurately submitted when the record:

(1) received an Application Acknowledgment Code of accepted;

(2) where applicable, contained the same data as the source medical bill and explanation of benefits; and

(3) to the extent supported by the format, contained all appropriate modifiers, code qualifiers, and data elements necessary to identify health care services, charges and payments.

(e) Insurance carriers are responsible for correcting and resubmitting rejected medical EDI records within 30 days of the action that triggered the reporting requirement. The insurance carrier's receipt of a rejection does not modify, extend or otherwise change the date the transaction is required to be reported to the division. The resubmitted medical EDI record must contain the same unique bill identification number as the previously rejected medical EDI record.

*§134.805. Records Required to be Reported.*

(a) Insurance carriers shall submit medical EDI records when the insurance carrier:

(1) pays a medical bill;

(2) reduces or denies payment for a medical bill;

(3) receives a refund for a medical bill; or

(4) discovers that a medical EDI record should not have been submitted to the division and the medical EDI record had previously been accepted by the division.

(b) Regardless of the Application Acknowledgment Code returned in an acknowledgment, medical EDI records are not considered received by the division if the medical EDI record:

(1) contains data which does not accurately reflect the code values used or actions taken when the insurance carrier processed the medical bill; or

(2) fails to contain a conditional data element and the mandatory trigger condition existed at the time the insurance carrier processed the medical bill.

(c) Except in situations where the health care provider included an invalid service or procedure code on the medical bill, rejected medical EDI records are not considered received and shall be corrected and resubmitted to the division as provided in §134.804(e) of this title (relating to Reporting Requirements). Medical EDI records submitted in the test environment are not considered received and do not comply with the reporting requirements of this section.

*§134.806. Records Excluded from Reporting.*

(a) Insurance carriers shall not report medical EDI records for health care services:

(1) rendered outside the United States;

(2) related to dates of injury before January 1, 1991;

(3) rendered at a Federal health care facility and the health care facility does not provide the insurance carrier with the data required to be reported;

(4) related to an injured employee's travel reimbursement as provided in §134.110 of this title (relating to Reimbursement of Injured Employee for Travel Expenses Incurred); or

(5) related to a request for reimbursement by a health care insurer in accordance with the provisions of Labor Code §409.0091.

(b) Insurance carriers shall not report interest and penalty payments paid on health care services, medical cost containment expenses, medical bill review expenses or data transmission expenses in medical EDI records.

*§134.807. State Specific Requirements.*

(a) A medical EDI transmission shall not exceed a file size of 1.5 megabytes. A transaction set shall not contain more than 100 medical EDI records in a claimant hierarchical loop.

(b) Insurance carriers shall submit medical EDI transactions using Secure File Transfer Protocol (SFTP). All alphabetic characters used in the SFTP file name must be lower case and the file must be compressed/zipped. Files that do not comply with these requirements or the naming convention may be rejected and placed in appropriate failure folders. Insurance carriers must monitor these folders for file failures and make corrections in accordance with §134.804(e) of this title (relating to Reporting Requirements).

(c) SFTP files must comply with the following naming convention:

(1) Two digit alphanumeric state indicator of 'tx';

(2) Nine digit trading partner Federal Employer Identification Number (FEIN);

(3) Nine digit trading partner postal code;

(4) Nine digit insurance carrier FEIN or 'xxxxxxxxx' if the file contains medical EDI transactions from different insurance carriers;

(5) Three digit record type '837';

(6) One character Test/Production indicator ('t' or 'p');

(7) Eight digit date file sent 'CCYYMMDD';

(8) Six digit time file sent 'HHMMSS';

(9) One character standard extension delimiter of '.'; and

(10) Three digit alphanumeric standard file extension of 'zip' or 'txt'.

(d) The transaction types accepted by the division include '00' original, '01' cancel, and '05' replacement.

(e) Insurance carriers are required to use the following delimiters:

(1) Date Element Separator--'*' asterisk;

(2) Sub-element Separator--':' colon; and

(3) Segment Terminator--'~' tilde.

(f) In addition to the requirements adopted under §134.803 of this title (relating to Reporting Standards), state reporting of medical EDI transactions shall comply with the following formatting requirements:

(1) Loop 2400 Service Line Information shall not contain more than one type of service. Only one of the following data segments may be contained in an iteration of this loop: SV1 Professional Service, SV2 Institutional Service, SV3 Dental Service or SV4 Pharmacy Service.

(2) When reporting compound medications, Loop 2400 Service Line Information SV4 Pharmacy Drug Service shall include a separate line for each reimbursable component of the compound medication. The compounding fee must be reported using a default NDC number equal to '99999999999' as a separate service line.

(3) When reporting pharmacy medical EDI records, the following data element definition clarifications apply:

(A) DN501 Total Charge Per Bill is the total amount charged by the pharmacy or pharmacy processing agent;

(B) DN511 Date Insurer Received Bill is the date the insurance carrier received the bill;

(C) DN512 Date Insurer Paid Bill is the date the insurance carrier paid the pharmacy or pharmacy processing agent;

(D) DN516 Total Amount Paid Per Bill is the total net amount the insurance carrier's agent actually paid to the pharmacy or pharmacy processing agent;

(E) DN638 Rendering Bill Provider Last/Group Name is the name of the dispensing pharmacy;

(F) DN690 Referring Provider Last/Group Name is the last name of the prescribing doctor; and

(G) DN691 Referring Provider First Name is the first name of the prescribing doctor.

*§134.808. Insurance Carrier EDI Compliance Coordinator and Trading Partners.*

(a) Insurance carriers may submit medical EDI records directly to the division or may contract with an external trading partner to submit the records on the insurance carrier's behalf.

(b) Each insurance carrier, including those using external trading partners, must designate one individual to the division as the EDI Compliance Coordinator and provide the individual's name, working title, mailing address, email address, and telephone number in the form and manner prescribed by the division. The EDI Compliance Coordinator must:

(1) be a centrally-located employee of the insurance carrier who has the responsibility for EDI reporting;

(2) receive and appropriately disperse data reporting information received from the division; and

(3) serve as the central compliance control for data reporting under this subchapter.

(c) At least five working days prior to sending its first transaction to the division under this subchapter, the insurance carrier shall send a notice to the division by fax or email at TxCOMP.Help@tdi.state.tx.us. The notice shall be in the form and manner established by the division. The notice shall include the name of the insurance carrier, the insurance carrier's FEIN, the insurance carrier's TxCOMP customer number, the name of the trading partner(s) authorized to conduct medical EDI transactions on behalf of the insurance carrier, the FEIN of the trading partner(s), and the EDI Compliance Coordinator's signature. The insurance carrier shall report changes within five working days of any amendment to data sharing agreements, including the addition or removal of any trading partners. The failure to timely submit updated information may result in the rejection of medical EDI records.

(d) At least five working days prior to sending its first test transaction to the division under this subchapter, the insurance carrier or trading partner sending the medical EDI transmission shall send a notice to the division by fax or email at TxCOMP.Help@tdi.state.tx.us. The notice shall be in the form and manner established by the division. The notice shall include the entity's name, FEIN, nine-digit postal code, address, and the technical contact's name, address, phone number, and email address. The insurance carrier or trading partner shall report changes within five working days of any amendment to the information required to be reported.

(e) Insurance carriers and trading partners must successfully complete testing prior to transmitting any production data. Trading partners must receive approval to submit data for at least one insurance carrier prior to initiating the testing process. Insurance carriers and trading partners must submit each transaction type during the testing process which can be successfully processed by the division. The division will not approve an insurance carrier or trading partner for production submissions until the insurance carrier or trading partner has:

(1) successfully submitted ten percent of its anticipated monthly volume per service type, not to exceed 100 bills per service type;

(2) received and reviewed the acknowledgments generated by the division; and

(3) correctly resubmitted rejected records identified in the acknowledgments.

(f) Insurance carriers are responsible for the acts or omissions of their trading partners. The insurance carrier commits an administrative violation if the insurance carrier or its trading partner fails to timely or accurately submit medical EDI records.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100161
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Earliest possible date of adoption: February 27, 2011
For further information, please call: (512) 804-4703

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# TITLE 34. PUBLIC FINANCE

## PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

### CHAPTER 1. CENTRAL ADMINISTRATION
### SUBCHAPTER A. PRACTICE AND PROCEDURES
### DIVISION 1. PRACTICE AND PROCEDURES

**34 TAC §1.9**

The Comptroller of Public Accounts proposes to amend §1.9, concerning position letter. The amendment is to streamline the hearings process by allowing the Tax Division to set a hearing at the State Office of Administrative Hearings without issuing a position letter.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be by allowing taxpayer hearings to be more expeditiously docketed at the State Office of Administrative Hearings. The proposed amendment would have no fiscal impact on small businesses. There is no anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Robin Robinson, Deputy General Counsel, General Counsel Division, P.O. Box 13528, Austin, Texas 78711-3528 or by email at robin.robinson@cpa.state.tx.us.

The amendment is proposed under Tax Code, §111.002, which provides the comptroller with authority to prescribe, adopt, and enforce rules relating to the administration and enforcement provisions of Tax Code, Title 2.

The amendment implements Tax Code, §§111.001, 111.009, and 111.105, which provide for the collection of taxes and redetermination and refund hearings.

*§1.9. Position Letter.*

(a) If the taxpayer's contentions have not been resolved pursuant to §1.8 of this title (relating to Resolution Prior to Issuance of a Position Letter), the assistant general counsel will review the Statement of Grounds, documentary evidence, and any additional evidence received from the taxpayer and a Position Letter will be sent to the taxpayer. The Position Letter will accept or reject, in whole or in part, each contention of the taxpayer, and set forth what the assistant general counsel finds is properly subject to or exempt from taxation.

(b) Pursuant to Tax Code, §111.105(e), the assistant general counsel may issue a written demand notice to the taxpayer requesting that all documentary evidence that would support facts or contentions raised by the taxpayer in connection with a refund claim be produced within a specified time. The time period specified in the written demand notice may not be less than 180 days from the date of the original refund claim, and not less than 60 days from the date of the notice. A taxpayer who fails to produce the requested documents within the specified time period may not introduce in evidence any of the documents that were not timely produced. The assigned administrative law judge cannot consider documents that were not produced within the specified deadline. This section is only applicable to the administrative hearing and has no effect on a judicial proceeding pending under Tax Code, Chapter 112.

(c) This section does not apply to hearings pursuant to Tax Code, §154.1142 or §155.0592.

(d) This section is optional for the Tax Division in cases for which:

(1) the statement of grounds does not contain the information required by §1.7 of this title (relating to Content of Statement of Grounds; Preliminary Conference);

(2) the dispute is the denial of a settlement pursuant to Tax Code, §§111.101 - 111.103; or

(3) State Office of Administrative Hearings (SOAH) can readily decide the matter without the position letter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 11, 2011.

TRD-201100105
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: February 27, 2011
For further information, please call: (512) 475-0387

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# CHAPTER 18. TOBACCO SETTLEMENT PERMANENT TRUST ACCOUNT

## 34 TAC §18.2

The Comptroller of Public Accounts proposes amendments to §18.2, concerning trust account distributions. The amendment will clarify the distribution formula to allow the committee some discretion in the calculation of the distributions in order to provide for predictable, stable, and sustainable distributions over time while maintaining the inflation adjusted value of the corpus.

John Heleman, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant revenue impact on the state or units of local government.

Mr. Heleman also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be by improving the management of the trust account's assets and preserving future distributions to county governments and hospital districts. The proposed amendment would have no fiscal impact on small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Paul Ballard, Chief Executive Officer, Texas Treasury Safekeeping Trust Company, 208 E. 10th Street, Austin, Texas 78704. If a person wants to ensure that the comptroller considers and responds to a comment made about this proposal, then the person must ensure that the comptroller receives the comment not later than the 30th day after the issue date of the *Texas Register* in which this proposal appears.

The amendment is proposed under Government Code, §403.1041(h), which authorizes the comptroller to adopt rules related to the management and implementation of the trust account.

The amendment implement Government Code, §403.1041(h).

*§18.2. Trust Account Distributions.*

(a) The trust account shall balance the present needs and interests of the political subdivisions with those of the future. The trust account distribution objectives shall be to:

(1) provide a predictable, stable stream of distributions over time;

(2) ensure that the inflation-adjusted value of distributions is maintained over the long-term; and

(3) ensure that the inflation-adjusted value of the corpus after distributions is maintained over the long-term.

(b) Subject to subsection (c) of this section, the actual distribution amount shall be 5.0% [~~5%~~] of the average market value of the trust account calculated as of the end of the calendar year immediately preceding the distribution. No more than 4.5% shall be distributed to the political subdivisions and the remainder shall be distributed to the distribution stabilization account when the distribution stabilization account balance is less than the maximum balance, which shall be equal to three times the amount actually distributed in the preceding year from the trust account to the political subdivisions. When the distribution stabilization account balance equals the maximum balance, this portion of the actual distribution amount shall not be distributed from the

trust account. [~~The actual distribution amount shall be distributed as follows:~~]

[~~(1) 4.5% to the political subdivisions; and~~]

[~~(2) 0.5% to the distribution stabilization account when the distribution stabilization account balance is less than the maximum balance, which shall be equal to three times the amount actually distributed in the preceding year from the trust account to the political subdivisions. When the distribution stabilization account balance equals the maximum balance, this 0.5% portion of the actual distribution amount shall not be distributed from the trust account.~~]

(c) If the net earnings of the trust account are less than the calculated actual distribution amount in subsection (b) of this section, the actual distribution amount shall not exceed the lesser of: 4.5% of the average market value or 4.5% of the year-end market value. The distribution [~~the amount in subsection (b)(1) of this section and~~] shall be funded from the sources, until exhausted, in the order provided as follows:

(1) adjusted current earnings;

(2) positive net earnings; then

(3) up to 50% of the balance of the distribution stabilization account.

(d) Any or all positive net earnings, not otherwise distributed as provided in subsection (c) of this section, may be distributed to the distribution stabilization account.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100150
Ashley Harden
General Counsel
Comptroller of Public Accounts
Earliest possible date of adoption: February 27, 2011
For further information, please call: (512) 475-0387

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# WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

## TITLE 1. ADMINISTRATION

### PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

### CHAPTER 354. MEDICAID HEALTH SERVICES

### SUBCHAPTER B. GENERAL PROVISIONS

**1 TAC §354.1452**

The Texas Health and Human Services Commission withdraws proposed new §354.1452, which appeared in the October 29, 2010, issue of the *Texas Register* (35 TexReg 9581).

Filed with the Office of the Secretary of State on January 12, 2011.

TRD-201100133
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 12, 2011
For further information, please call: (512) 424-6900

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# ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

## TITLE 1. ADMINISTRATION

## PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

## CHAPTER 354. MEDICAID HEALTH SERVICES

## SUBCHAPTER A. PURCHASED HEALTH SERVICES

## DIVISION 3. MEDICAID HOME HEALTH SERVICES

### 1 TAC §354.1040

The Texas Health and Human Services Commission (HHSC) adopts new §354.1040, concerning Requirements for Wheeled Mobility Systems, with changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 9967). The text of the rule will be republished.

Background and Justification

Senate Bill 1804, 81st Legislature, Regular Session, 2009, amends Human Resources Code, Chapter 32, by adding new §32.0424, which sets out requirements for Medicaid reimbursement for the provision of, or a major modification to, a wheeled mobility system. The new statute defines "qualified rehabilitation professional" (QRP) and "wheeled mobility system" (or system), identifying the QRP's roles and responsibilities. The QRP must be present at and involved in any clinical assessment of the recipient that is required for reimbursement. In addition, the QRP must be present at the delivery of the system to direct a fitting to ensure that the system is appropriate for the recipient and verify that the system functions appropriately for the recipient. The new rule implements §32.0424.

Comments

HHSC received three comments during the 30-day comment period, which ended December 12, 2010. Two of the comments received expressed support for the proposed new rule. These comments came from a representative of the Texas Rehabilitation Providers' Council (TxRPC), and from an Assistive Technology Professional. The final comment came from a representative of TxRPC who asked for clarification regarding the proposed rule. The comment, along with HHSC's response, follows.

Comment: TxRPC asks for clarification regarding the effective date of the requirements set forth in the proposed rule. Will the requirements of the proposed rule apply if a wheeled mobility system is authorized and the clinical assessment is done prior to September 1, 2011, but the wheeled mobility system is delivered on or after that date?

Response: HHSC acknowledges the comment. The requirements of the rule apply to wheeled mobility systems delivered on or after September 1, 2011, and to the QRP functions performed related to a wheeled mobility system delivered on or after September 1, 2011 and after the effective date of the associated rates as determined by HHSC. HHSC added new subsection (h) to clarify the effective dates for services provided.

Statutory Authority

The new rule is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas.

*§354.1040. Requirements for Wheeled Mobility Systems.*

(a) Purpose. This section details the requirements for receiving reimbursement for the provision of, or the performance of a major modification to, a wheeled mobility system. This section implements §32.0424 of the Human Resources Code.

(b) Definitions. The following words and terms when used in this section shall have the following meanings, unless the context clearly indicates otherwise.

(1) Occupational therapist (OT)--A person licensed by the Texas Board of Occupational Therapy Examiners to practice occupational therapy, as defined in §454.002(4), of the Texas Occupations Code (relating to Definitions).

(2) Physical therapist (PT)--A person licensed by the Texas Board of Physical Therapy Examiners to practice physical therapy, as defined in §354.1121 of this chapter (relating to Definitions).

(3) Qualified rehabilitation professional (QRP)--A person who holds one or more of the following certifications:

(A) Holds a certification as an assistive technology professional or a rehabilitation engineering technologist issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA);

(B) Holds a certification as a seating and mobility specialist issued by, and in good standing with, RESNA; and/or

(C) Holds a certification as a certified rehabilitation technology supplier issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS).

(4) Wheeled Mobility System--An item of durable medical equipment (DME) that is a customized powered or manual mobility device or a feature or component of the device, including the following:

(A) Seated positioning components;

(B) Powered or manual seating options;

(C) Specialty driving controls;

(D) Multiple adjustment frame;

(E) Nonstandard performance options; and

(F) Other complex or specialized components.

(c) Roles and responsibilities. The following persons, when referenced in this section, shall have the following roles in the provision of, or the performance of a major modification to, a wheeled mobility system, unless the context clearly indicates otherwise.

(1) Occupational therapist (OT)--The occupational therapist is responsible for completing the clinical assessment of a recipient required for obtaining a wheeled mobility system. The assessment shall include detailed documentation of medical need for specific mobility or seating equipment and all necessary accessories.

(2) Physical therapist (PT)--The physical therapist is responsible for completing the clinical assessment of a recipient required for obtaining a wheeled mobility system. The assessment shall include detailed documentation of medical need for specific mobility or seating equipment and all necessary accessories.

(3) Qualified rehabilitation professional (QRP)--The QRP is required to:

(A) Be present for and involved in the clinical assessment of the recipient;

(B) Be present at the time of delivery of the wheeled mobility system to direct the fitting of the wheeled mobility system to ensure that the system is appropriate for the recipient; and

(C) Verify that the wheeled mobility system functions correctly relative to the recipient.

(4) A person that is licensed as an OT and/or a PT, and is also certified as a QRP, may perform either the role of the therapist or the QRP during the clinical assessment of the client, but cannot serve in both roles at the same time.

(d) Benefit. Wheeled mobility systems are a Medicaid benefit when the following criteria are met.

(1) All the requirements for DME, as detailed in §354.1039 of this chapter (relating to Home Health Services Benefits and Limitations) are met.

(2) Wheeled mobility systems are provided by an enrolled DME supplier that directly employs or contracts with a QRP.

(3) An enrolled DME supplier obtains prior authorization for wheeled mobility systems from the Texas Health and Human Services Commission (HHSC) or its designee.

(e) Prior authorization requirements. The following documentation must be submitted in a manner approved by HHSC or its designee to obtain prior authorization for a wheeled mobility system.

(1) A signed and dated physician's prescription, or other such documentation as directed by HHSC, that details a wheeled mobility system, including all necessary components, needed by the recipient;

(2) A clinical assessment that includes detailed documentation of medical need for specific mobility or seating equipment and all necessary accessories, signed and dated by an OT or PT authorized to perform the assessment;

(3) Documentation in a form or manner directed by HHSC or its designee attesting that a QRP was present for and involved in the clinical assessment of the recipient; and

(4) Any other documentation deemed necessary by HHSC or its designee to adequately explain the medical necessity of the requested equipment.

(f) Requirements for reimbursement. Reimbursement for the provision of, or the performance of a major modification to, a wheeled mobility system will be considered only when:

(1) The system is delivered to a recipient by a Medicaid-enrolled DME provider that directly employs or contracts with, a QRP, and the QRP was present and involved in the clinical assessment of the recipient for the requested wheeled mobility system;

(2) At the time the wheeled mobility system is delivered to the recipient, the QRP is present and responsible for:

(A) directing the fitting to ensure that the system is appropriate for the recipient; and

(B) verifying that the system functions correctly relative to the recipient.

(g) Documentation requirements for reimbursement. The following documentation must be submitted by the enrolled DME supplier with the claim for consideration of reimbursement for a wheeled mobility system in a manner approved by HHSC or its designee.

(1) A signed and dated HHSC DME Certification and Receipt Form as required in §354.1185 of this chapter (relating to Provider Compliance with Durable Medical Equipment (DME) Certification Requirements); and

(2) Documentation in a form and manner as directed by HHSC or its designee attesting that a QRP was present at the time of delivery and:

(A) directed the fitting of the wheeled mobility system to ensure that the system was appropriate for the recipient; and

(B) verified that the wheeled mobility system functions correctly relative to the recipient.

(h) Effective dates for services provided. The provisions of this section apply to the following services:

(1) Wheeled mobility systems delivered on or after September 1, 2011;

(2) A major modification to a wheeled mobility system provided on or after September 1, 2011; and

(3) QRP functions, including participating in a clinical assessment of a client and directing the fitting of a wheeled mobility system, related to the provision of, or a major modification to, a wheeled mobility system when:

(A) the wheeled mobility system is delivered on or after September 1, 2011; and

(B) the QRP functions are performed after the effective date of the associated rates as determined by HHSC.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100148

Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Effective date: February 3, 2011
Proposal publication date: November 12, 2010
For further information, please call: (512) 424-6900

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# TITLE 4. AGRICULTURE

## PART 1. TEXAS DEPARTMENT OF AGRICULTURE

### CHAPTER 4. PRESCRIBED BURNING BOARD ENFORCEMENT PROGRAM

### SUBCHAPTER A. ENFORCEMENT, INVESTIGATION, PENALTIES AND PROCEDURES

**4 TAC §§4.1 - 4.7**

The Texas Department of Agriculture (department) adopts new Chapter 4, Subchapter A, §§4.1 - 4.7, concerning the Prescribed Burning Board Enforcement Program for certified and insured prescribed burn managers (CPBM or CPBMs), without changes to the proposed text as published in the November 26, 2010, issue of the *Texas Register* (35 TexReg 10371).

The new sections are adopted to establish the department's enforcement program and procedures for the Prescribed Burning program, as provided for in the Natural Resources Code, Chapter 153, and Agriculture Code, Chapter 12. The new sections provide definitions, procedures for complaints and investigations, enforcement, review as contested case and settlements, and a schedule of disciplinary sanctions. The new sections and schedule of disciplinary sanctions were developed with input from the Prescribed Burning Board and are intended to promote public safety in regard to prescribed burning by receiving complaints against CPBMs and taking appropriate enforcement action.

No comments were received on the proposal.

Chapter 4, Subchapter A, §§4.1 - 4.7 are adopted under Agriculture Code, §12.016, which provides the department with the authority to adopt rules to administer its duties under the Code; Chapter 153, Subchapter D, of the Natural Resources Code, which requires the department to: receive and process complaints concerning CPBMs; impose, as appropriate, administrative penalties as provided by §§12.020, 12.0201, 12.0202, and 12.0261 of the Agriculture Code; and §153.102, which requires the department to adopt by rule a schedule of disciplinary sanctions the department may impose against a CPBM.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100155
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Effective date: February 3, 2011
Proposal publication date: November 26, 2010
For further information, please call: (512) 463-4075

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## PART 13. PRESCRIBED BURNING BOARD

### CHAPTER 225. GENERAL PROVISIONS

**4 TAC §225.1, §225.2**

The Texas Department of Agriculture (department), on behalf of the Prescribed Burning Board (PBB), adopts amendments to Title 4, Part 13, Chapter 225, §225.1, and new §225.2, concerning administration of the prescribed burning program, without changes to the proposal published in the November 26, 2010, issue of the *Texas Register* (35 TexReg 10372).

The amended and new section are adopted to promote public safety and to provide administrative efficiency to the PBB in carrying out its duties set forth in §153.046 of the Natural Resources Code. Section 225.1(5) is amended to refer to a "certified and insured prescribed burn manager," consistent with the statutory revisions to Chapter 153 of the Natural Resources Code made by the 81st Texas Legislature in Senate Bill 1016. New §225.2 requires certified and insured prescribed burn managers to timely respond to all requests for information from the PBB and subject certified and insured prescribed burn managers to potential administrative penalties for noncompliance.

No comments were received on the proposal.

The amended and new section are adopted under the Natural Resources Code, §153.046, which provides the Board with the authority to establish standards for prescribed burning, and standards for certification, recertification, and training for prescribed burn managers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100156
Dolores Alvarado Hibbs
General Counsel, Texas Department of Agriculture
Prescribed Burning Board
Effective date: February 3, 2011
Proposal publication date: November 26, 2010
For further information, please call: (512) 463-4075

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### CHAPTER 227. CERTIFICATION, RECERTIFICATION, RENEWAL AND RECORDS

## SUBCHAPTER A. CERTIFICATION REQUIREMENTS

**4 TAC §227.2**

The Texas Department of Agriculture (department), on behalf of the Prescribed Burning Board (PBB), adopts an amendment to §227.2, concerning experience requirements for certification as a prescribed burn manager, without changes to the proposal published in the November 26, 2010, issue of the *Texas Register* (35 TexReg 10373).

The amendment is adopted to clarify that the National Wildfire Coordinating Group's "Burn Boss II" qualification, and experience with prescribed fire in regions outside Texas with a specific fuel type applicable to a particular region in Texas, will qualify for the educational and training requirements to obtain certification as a commercial or private certified prescribed burn manager in Texas. The amendment is also adopted to promote public safety and to provide administrative efficiency to the PBB in carrying out its duties set forth in §153.046 of the Natural Resources Code.

No comments were received on the proposal.

The amendment is adopted under the Natural Resources Code, §153.046, which provides the Board with the authority to establish standards for prescribed burning, and standards for certification, recertification, and training for prescribed burn managers.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100157
Dolores Alvarado Hibbs
General Counsel, Texas Department of Agriculture
Prescribed Burning Board
Effective date: February 3, 2011
Proposal publication date: November 26, 2010
For further information, please call: (512) 463-4075

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# TITLE 16. ECONOMIC REGULATION

# PART 1. RAILROAD COMMISSION OF TEXAS

## CHAPTER 4. ENVIRONMENTAL PROTECTION

The Railroad Commission of Texas (Commission) adopts amendments to §§4.204, 4.217, 4.223, 4.420, 4.620, and 4.626, relating to Definitions; General Permit Provisions; Permit Renewal; Acceptance or Rejection of an Application; Permit for Surface Disposal; and Recordkeeping, without changes to the versions published in the November 19, 2010, issue of the *Texas Register* (35 TexReg 10122). The Commission adopts some non-substantive corrections to cross-references to other rules within this title, and adopts these amendments in conjunction with the four-year review required by Texas Government Code, §2001.039.

The Commission received no comments on the proposed amendments or rule review.

## SUBCHAPTER B. COMMERCIAL RECYCLING

**16 TAC §§4.204, 4.217, 4.223**

The Commission adopts the amendments pursuant to Texas Natural Resources Code, §81.051 and §81.052, which provide the Commission with jurisdiction over all persons owning or engaged in drilling or operating oil or gas wells in Texas and the authority to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission.

Texas Natural Resources Code, §81.051 and §81.052, are affected by the adopted amendments.

Statutory authority: Texas Natural Resources Code, §81.051 and §81.052.

Cross-reference to statute: Texas Natural Resources Code, §81.051 and §81.052.

Issued in Austin, Texas, on January 13, 2011.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100152
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: February 3, 2011
Proposal publication date: November 19, 2010
For further information, please call: (512) 475-1295

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## SUBCHAPTER D. RAILROAD COMMISSION OF TEXAS VOLUNTARY CLEANUP PROGRAM

**16 TAC §4.420**

The Commission adopts the amendments pursuant to Texas Natural Resources Code, §81.051 and §81.052, which provide the Commission with jurisdiction over all persons owning or engaged in drilling or operating oil or gas wells in Texas and the authority to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission.

Texas Natural Resources Code, §81.051 and §81.052, are affected by the adopted amendments.

Statutory authority: Texas Natural Resources Code, §81.051 and §81.052.

Cross-reference to statute: Texas Natural Resources Code, §81.051 and §81.052.

Issued in Austin, Texas, on January 13, 2011.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-201100153
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: February 3, 2011
Proposal publication date: November 19, 2010
For further information, please call: (512) 475-1295

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## SUBCHAPTER F. OIL AND GAS NORM

### 16 TAC §4.620, §4.626

The Commission adopts the amendments pursuant to Texas Natural Resources Code, §81.051 and §81.052, which provide the Commission with jurisdiction over all persons owning or engaged in drilling or operating oil or gas wells in Texas and the authority to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission.

Texas Natural Resources Code, §81.051 and §81.052, are affected by the adopted amendments.

Statutory authority: Texas Natural Resources Code, §81.051 and §81.052.

Cross-reference to statute: Texas Natural Resources Code, §81.051 and §81.052.

Issued in Austin, Texas, on January 13, 2011.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-201100154
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: February 3, 2011
Proposal publication date: November 19, 2010
For further information, please call: (512) 475-1295

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# CHAPTER 11. SURFACE MINING AND RECLAMATION DIVISION

## SUBCHAPTER C. SUBSTANTIVE RULES--URANIUM EXPLORATION AND SURFACE MINING

## DIVISION 5. URANIUM EXPLORATION PERMITS AND PERMIT FEES

### 16 TAC §11.136

The Railroad Commission of Texas adopts new §11.136, relating to Uranium Exploration Permit Fees, with changes to the version published in the November 19, 2010, issue of the *Texas Register* (35 TexReg 10124). The Commission adopts the new rule to fund the regulatory program as necessary to implement the Commission's statutory authority for uranium exploration enacted by House Bill 3837, 80th Legislature (2007).

New §11.136 pertains to uranium exploration permit fees. The Commission adopts a flat fee of $5,500 for permit-application processing and for annual permit-renewal applications. The Commission will refund $4,500 of the application fee if the application is not approved. The Commission also adopts non-refundable $500 permit amendment and transfer application fees. In addition, the Commission will charge permittees $45 for each borehole drilled during the 12-month permit term. New subsection (e) requires that these per-borehole fees be paid with the submission of monthly borehole casing or plugging reports (Forms SMRD-38U or SMRD-39U, respectively, that were adopted by the Commission in a separate rulemaking proceeding on October 12, 2010, and became effective on November 1, 2010).

The Commission received one comment from the Texas Mining and Reclamation Association-Uranium Committee ("TMRA-UC"). TMRA-UC's comments stated neither support for nor opposition to the proposed new rule, but offered suggestions for revisions to some of the rule's provisions.

TMRA-UC proposed two alternative fee structures for Commission consideration. The first alternative fee structure would revise the proposed flat $45 fee per drilled borehole that exploration permittees would be required to pay and would establish a tiered exploration fee structure wherein permittees would pay a $60 fee for each exploration borehole drilled for the first 100 boreholes and a $30 fee for each exploration borehole drilled over and above the first 100 boreholes.

The second alternative fee structure proposed by TMRA-UC would establish new definitions to distinguish between exploration boreholes and delineation boreholes to create different fee amounts for the two types of boreholes. TMRA-UC proposed that an exploration borehole be defined as "an uncased hole located horizontally or vertically outside an area permitted under the Underground Injection Control (UIC) Program at the Texas Commission on Environmental Quality created with a drill, auger, or other boring tool for exploring strata in search of uranium deposits," and that a delineation borehole be defined as "an uncased hole located within the horizontal or vertical extent of an area permitted under the Underground Injection Control (UIC) Program at the Texas Commission on Environmental Quality created with a drill, auger, or other boring tool for the purpose of delineation of an uranium ore pattern for well field installation." Under the scenario established with these definitions, TMRA-UC recommended a fee of $60 for each drilled exploration borehole and $30 for each delineation borehole. TMRA-UC did not offer a rationale for the first alternative fee schedule, but suggested that the second alternative fee schedule would place more of the financial burden (i.e., fees) on those permit holders that engage in more borehole drilling activities and thus will require the most resources of the Commission in the regulation of such activities.

TMRA-UC's basis for this rationale is unclear, and the Commission does not concur with the suggested changes to the pro-

posed fee structure. The level of regulatory effort necessary to ensure that a borehole is adequately plugged and abandoned, or that it is properly cased for use as a well is independent of its location within a UIC area permitted by the Texas Commission on Environmental Quality (TCEQ). In addition, the regulatory effort to verify proper plugging or casing of an exploration borehole is essentially the same regardless of the number of boreholes within a uranium exploration permit area. The Commission's position on separately defining "exploration" and "delineation" boreholes was clearly set forth in the Commission's adoption order for various uranium exploration regulations in Chapter 11 published in the *Texas Register* on October 29, 2010 (35 TexReg 9724), as follows: "no distinction is necessary for boreholes drilled for orebody delineation ('delineation' boreholes), as such drilling is still considered to be an exploration activity whether or not the borehole is plugged immediately or later cased for use as a well." (35 TexReg 9725, annotation added.) Regardless of whether a borehole is located within a TCEQ-permitted production area, unless and until such hole is properly cased and transferred to the TCEQ permit, it remains under the Commission's jurisdiction. The Commission must inspect each borehole and all records of the borehole status.

TMRA-UC also recommended that the Commission add language to proposed §11.136 to establish a reporting requirement for the Commission's Surface Mining and Reclamation Division on an annual basis. This report would include information on the amount of fee revenue collected by the Commission pursuant to §11.136. TMRA-UC stated that such reporting is necessary to ascertain whether sufficient revenue is being generated to support the Commission in its effort to implement the regulatory program established by House Bill 3837 in 2007. The Commission does not agree with creating this suggested additional reporting requirement. The regulatory program established by House Bill 3837 was intended to be funded by the regulated industry, thus not requiring funds from General Revenue sources. The Commission's Surface Mining and Reclamation Division and the Administration Division can ascertain whether sufficient funds are being collected to implement the regulatory program and meet the objectives of the Act. The Commissioners have access to this information upon their request at any time. Further, the amount of fee revenue collected under this program is public information and can be requested by the public at any time.

To be consistent with terminology used elsewhere in the adopted rules under this chapter, the Commission is adopting a revision in the wording of proposed subsection (b) in which the $500 *amendment* fee is clarified to be assessed for an application for *revision* to an exploration permit. The Commission has also amended Form SMRD-3U, Application to Conduct Uranium Exploration Activities By Drilling, to be consistent with the fee structure in new §11.136.

The Commission adopts the new rule under Texas Natural Resources Code, §131.021, which authorizes the Commission to promulgate rules pertaining to surface uranium mining and exploration operations; Texas Natural Resources Code, §131.355, which authorizes the Commission to impose fees and mandates the fee collection authorized in House Bill 3837, 80th Legislature (2007) and Senate Bill 1, Article VI, Railroad Commission Rider 13, 81st Legislature (2009), which requires the Commission to assess fees sufficient to generate revenue to cover the contingent general revenue appropriation.

Texas Natural Resources Code, §131.001, *et seq.,* as amended by House Bill 3837, 80th Legislature (2007) is affected by the adopted new rule.

Statutory authority: Texas Natural Resources Code, §131.001, *et seq.,* as amended by House Bill 3837, 80th Legislature (2007).

Cross-reference to statute: Texas Natural Resources Code, §131.001, *et seq.,* as amended by House Bill 3837, 80th Legislature (2007).

Issued in Austin, Texas, on January 13, 2011.

*§11.136. Uranium Exploration Permit Fees.*

(a) Initial uranium exploration permit fee. Each applicant for a uranium exploration permit shall pay to the Commission a uranium exploration permit fee consisting of:

(1) a permit-application filing fee of $5,500, to be submitted with the application; and

(2) an amount equal to $45 for each exploration borehole drilled during each month of the approved 12-month permit term, non-refundable, and payable as described in subsection (e) of this section.

(b) Uranium exploration permit revision fee. Each applicant for a uranium exploration permit revision shall pay to the Commission a non-refundable permit amendment fee of $500.

(c) Uranium exploration permit renewal fee. Each applicant for renewal of a uranium exploration permit shall pay to the Commission a fee consisting of:

(1) a permit-application filing fee of $5,500, to be submitted with the renewal application; and

(2) an amount equal to $45 for each exploration borehole drilled during each remaining month of the approved 12-month permit term, non-refundable, and payable as described in subsection (e) of this section.

(d) Uranium exploration permit transfer fee. Each applicant for the transfer of a uranium exploration permit pursuant to §11.135 of this title (relating to Uranium Exploration Permit Transfer) shall pay to the Commission a non-refundable permit transfer application fee of $500.

(e) Schedule. Payment of the per-hole exploration borehole fee required in subsection (a) of this section shall be submitted to the Commission with the monthly borehole plugging reports (Form SMRD-39U, Borehole Plugging Report, and Form SMRD-38U, Cased Exploration Well Completion Report) filed pursuant to §11.139 of this title (relating to Uranium Exploration Drill Site Plugging and Reporting Requirements).

(f) Refunds. If a new or renewal application for uranium exploration is not approved, the Commission will refund $4,500 of the permit-application filing fee, without interest, to the applicant.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2011.

TRD-201100135

Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: February 2, 2011
Proposal publication date: November 19, 2010
For further information, please call: (512) 475-1295

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# TITLE 19. EDUCATION

## PART 2. TEXAS EDUCATION AGENCY

### CHAPTER 89. ADAPTATIONS FOR SPECIAL POPULATIONS

### SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING SPECIAL EDUCATION SERVICES

### DIVISION 2. CLARIFICATION OF PROVISIONS IN FEDERAL REGULATIONS AND STATE LAW

**19 TAC §89.1070**

The Texas Education Agency (TEA) adopts an amendment to §89.1070, concerning special education services. The amendment is adopted without changes to the proposed text as published in the October 15, 2010, issue of the *Texas Register* (35 TexReg 9205) and will not be republished. The section specifies graduation requirements for students receiving special education services. The adopted amendment reflects changes to assessment and curriculum requirements for graduation for students receiving special education services as required by House Bill (HB) 3, 81st Texas Legislature, 2009.

HB 3, 81st Texas Legislature, 2009, amended the Texas Education Code (TEC), §39.023, to include changes to graduation requirements effective September 1, 2009. As a result of the changes to the state law, 19 TAC §89.1070 has been amended to ensure school district compliance with new procedural requirements.

In accordance with state and federal law, an admission, review, and dismissal (ARD) committee may determine that, for a student receiving special education services, a locally developed course is an appropriate substitute for a course that meets state graduation requirements for the minimum high school program. Under current policy, however, there is no requirement for locally developed courses to be aligned with the courses for which they substitute. For example, a student taking Consumer Math or Fundamentals of Math to substitute for Algebra I or Geometry may not receive adequate instruction in the Texas essential knowledge and skills (TEKS) for Algebra I or Geometry, which are both required to be assessed through end-of-course (EOC) assessments. Therefore, a student taking a locally developed course as a substitute for an assessed course would not be prepared to participate in a state assessment. This would include students receiving special education services participating in the general assessments as well as alternate assessments.

Beginning with the 2011-2012 school year, school districts will be required to review the content of locally developed courses for alignment with the TEKS to ensure students receive instruction that is aligned with the required course and respective EOC assessment.

A stakeholder meeting of parents, advocates, school districts, support personnel organizations, and teacher and administrator organizations was convened in August 2010 during the development of the rule changes. Section 89.1070 has been amended to reflect assessment and curriculum requirements for graduation as required by HB 3, as follows.

Subsection (b)(1) was amended to update language relating to assessments and include a reference to the performance standards established in the TEC, Chapter 39. Subsection (b)(1)-(3) was amended to include references to the curriculum standards a special education student may be required to complete to graduate and be awarded a high school diploma. Subsection (b)(2) was amended to clarify the role of the ARD committee in determining the level of performance necessary for graduation.

In addition, to more clearly organize the four conditions under which a student with a disability can graduate, the section was reorganized to move current subsections (c) and (d) to new subsection (b)(3) and (4). Subsequent subsections were re-lettered accordingly and technical corrections were made to update cross references.

The adopted amendment ensures that a locally developed course substituting for an assessed course must be aligned with the curriculum standards. The adopted amendment does not add any new reporting requirements; however, new Public Education Information Management System (PEIMS) codes will be created to correspond with courses for which modified and alternate EOC assessments are developed.

The adopted amendment has no new locally maintained paperwork requirements.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 15, 2010, and ended November 15, 2010. In addition, a public hearing on the proposed amendment was conducted on October 19, 2010, through the Texas Education Telecommunications Network (TETN) at each of the 20 regional education service centers. Following is a summary of public comments received, including those received at the public hearing, and corresponding agency responses regarding the proposed amendment to 19 TAC Chapter 89, Adaptations for Special Populations, Subchapter AA, Commissioner's Rules Concerning Special Education Services, Division 2, Clarification of Provisions in Federal Regulations and State Law, §89.1070, Graduation Requirements.

Comment: An educator asked if the new EOCs will be modified like TAKS (Accommodated) or TAKS-M or will special education students take the same EOC as Algebra I or Geometry students.

Agency Response: The agency offers the following clarification. For students receiving special education services, modified and alternate versions of the State of Texas Assessments of Academic Readiness (STAAR) will be developed, although not all 12 end-of-course assessments will be developed because Algebra II, chemistry, and physics courses are not required on the Minimum High School Program (MHSP) and all students taking STAAR modified and alternate assessments are on the MHSP as they receive modified instruction. The current plan is to develop both modified and alternate versions of the following EOC

assessments beginning in 2012: Algebra I, Geometry, English I, English II, Biology, and World Geography. Modified and alternate versions of English III, World History, and US History will be developed in future years.

Comment: An educator suggested revising §89.1070(b)(3) to add "must" prior to the phrase "meet one of the following" to read, "The student graduating under this subsection must also successfully complete the student's individualized education program (IEP) and must meet one of the following conditions, consistent with the IEP."

Agency Response: The agency disagrees and has maintained language as published as proposed. The language accurately reflects requirements in rule and, therefore, the suggested grammatical change is not necessary.

Comment: An educator recommended revising §89.1070(b)(3)(A)-(C) to reflect the language in the State Performance Plan Indicators 13 and 14. The educator also recommended eliminating §89.1070(e).

Agency Response: The agency disagrees and has maintained language as published as proposed. Language in the State Performance Plan is subject to change on an annual basis, which could necessitate changing the rule annually to preserve alignment. Section 89.1070(e), as written, defines terms referenced in §89.1070(b)(3)(A).

Comment: An educator recommended revising §89.1070(b)(4) to provide an option that would allow students to graduate and be awarded a regular high school diploma under the minimum high school program upon completion of the number of credits set by the ARD committee. The educator further suggested adding language to clarify that students who have not completed the credit requirements for graduation may be awarded a certificate of attendance.

Agency Response: The agency disagrees and has maintained language as published as proposed. Students who no longer meet the age eligibility requirements and have completed the requirements specified in their IEPs may be awarded a regular high school diploma. The ARD committee does not have the authority to establish the number of credits required for graduation. In addition, there is no provision in state law that authorizes school districts to issue certificates of attendance. School districts may only issue diplomas and certificates of coursework completion.

The amendment is adopted under 34 Code of Federal Regulations (CFR), §300.100, which requires states to have policies and procedures in place to ensure that they meet the conditions in 34 CFR, §§300.101-300.176; 34 CFR, §300.160, which requires states to ensure that all children with disabilities are included in all state and districtwide assessment programs with appropriate accommodations and alternate assessments, if necessary, as indicated in their respective individualized education programs; TEC, §28.0212, which provides that a student's individualized education program may be used as the student's personal graduation plan; TEC, §28.0213, which provides that a student's admission, review, and dismissal committee shall design an intensive program of instruction for a student who does not perform satisfactorily on a required state assessment; TEC, §29.001, which authorizes the commissioner of education to adopt rules for the administration and funding of the special education program; TEC, §29.003, which authorizes the commissioner to develop specific eligibility criteria for the special education program; TEC, §29.005(a), which requires that a committee composed of the persons required under 20 USC, §1401(11), develop a student's individualized education program; TEC, §39.023(c), which requires the agency to adopt end-of-course assessment instruments for certain core academic courses and provides that a student's admission, review, and dismissal committee shall determine whether any allowable modification is necessary in administering to the student an end-of-course assessment; and TEC, §42.003, which outlines the student eligibility requirements for the benefits of the Foundation School Program.

The amendment implements 34 CFR, §300.100 and §300.160, and the TEC, §§28.0212, 28.0213, 29.001, 29.003, 29.005(a), 39.023(c), and 42.003.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100158
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
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Proposal publication date: October 15, 2010
For further information, please call: (512) 475-1497

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# CHAPTER 109. BUDGETING, ACCOUNTING, AND AUDITING

## SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING FINANCIAL ACCOUNTABILITY

## DIVISION 1. FINANCIAL ACCOUNTABILITY RATING SYSTEM

### 19 TAC §§109.1002 - 109.1005

The Texas Education Agency (TEA) adopts amendments to §§109.1002-109.1005, concerning the financial accountability rating system. The amendments to §109.1002 and §109.1005 are adopted with changes to the proposed text as published in the October 22, 2010, issue of the *Texas Register* (35 TexReg 9459). The amendments to §109.1003 and §109.1004 are adopted without changes to the proposed text as published in the October 22, 2010, issue of the *Texas Register* (35 TexReg 9459) and will not be republished. The sections establish provisions that detail the ratings, types of ratings, criteria, reporting, and sanctions for the financial accountability rating system. The adopted amendments update the School Financial Integrity Rating System of Texas (School FIRST) by specifying new provisions for implementation beginning with fiscal year 2010-2011, including the deletion of one non-critical school district indicator and the addition of eighteen open-enrollment charter school indicators, along with new rating worksheets and calculations that reflect these changes. The adopted amendments to the rating system better align School FIRST for the two types of entities and clarify certain aspects of the School FIRST calculations. Additionally, the adopted amendments establish a

process for lowering a financial accountability rating after initial assignment if determined necessary by the commissioner.

House Bill (HB) 3, 81st Texas Legislature, 2009, modified and renumbered the Texas Education Code (TEC), Chapter 39, Subchapter I, Financial Accountability, and established Chapter 39, Subchapter D, Financial Accountability. Rules in 19 TAC Chapter 109, Budgeting, Accounting, and Auditing, Subchapter AA, Commissioner's Rules Concerning Financial Accountability Rating System, establish provisions that detail the purpose, ratings, types of ratings, criteria, reporting, and sanctions for the financial accountability rating system, in accordance with Senate Bill 218, 77th Texas Legislature, 2001, and HB 3. The rules include the financial accountability rating forms that explain the indicators that the TEA will analyze to assign school district and open-enrollment charter school financial accountability ratings. These forms specify the minimum financial accountability rating information that school districts and open-enrollment charter schools are to report to parents and taxpayers.

The adopted amendments to 19 TAC Chapter 109, Subchapter AA, update the rating system by specifying new provisions to be implemented beginning with fiscal year 2010-2011. The changes to the rating system better align School FIRST for school districts and open-enrollment charter schools and clarify certain aspects of the School FIRST calculations. Specifically, the adopted amendments to 19 TAC Chapter 109, Subchapter AA, are as follows.

The adopted amendment to 19 TAC §109.1002, Financial Accountability Ratings, updates the rating system by adding new subsections (f) and (g) to specify new provisions that will be implemented beginning with fiscal year 2010-2011, including the deletion of one non-critical school district indicator and the addition of eighteen open-enrollment charter school indicators, along with new rating worksheets and calculations that reflect these changes. The adopted rating system is applicable to financial accountability ratings assigned beginning with data from fiscal year 2010-2011 (the final ratings that will be issued in summer 2012).

In 19 TAC §109.1002, adopted new subsection (f) establishes the financial accountability rating indicators used to determine a school district rating beginning with fiscal year 2010-2011 by adding a new rating worksheet in Figure: 19 TAC §109.1002(f). The adopted new worksheet includes 21 indicators used to calculate a maximum score of 75 points and differs from the worksheet for previous fiscal years as follows:

Indicator 7, which referred to a school district's academic rating, is deleted as a rating indicator.

Indicators 8 through 22 are renumbered accordingly.

In response to public comment, Indicator 9 was changed at adoption to delete the words "per student" from the explanation referring to property taxes collected in the rating worksheet calculations page. There was no change in the calculation.

Indicator 11 is modified to provide additional examples.

Indicator 21 is adjusted to reflect lower interest rates.

In 19 TAC §109.1002, adopted new subsection (g) establishes the financial accountability rating indicators used to determine an open-enrollment charter school rating beginning with fiscal year 2010-2011 by adding a new rating worksheet in Figure: 19 TAC §109.1002(g). The adopted new worksheet adds 18 indicators for a total of 21 indicators used to calculate a maximum score of 75 points. In response to public comment, Indicator 7 was changed at adoption to clarify the description to match the actual calculation.

To reflect that changes were made to the figures referenced in subsections (f) and (g) since published as proposed, the date "July 2010" was changed to "December 2010." This change reflects the most current version of the financial accountability rating forms.

The adopted amendment to 19 TAC §109.1002 also reletters existing subsections (f) and (g). Additionally, relettered subsection (i), formerly subsection (g), clarifies that the financial accountability rating for a particular year will always be based on audited data from the previous fiscal year and establishes the rating to be assigned to an entity that fails to submit its annual financial and compliance report on a timely basis.

The adopted amendment to 19 TAC §109.1003, Types of Financial Accountability Ratings, updates language to align the types of ratings assigned to charter schools and traditional school districts and provides for the lowering of a financial accountability rating based on findings of an investigation. Additionally, subsection (c) is added to specify when ratings are in effect and the circumstances under which a rating may be revised after initial assignment.

The adopted amendment to 19 TAC §109.1004, Criteria for Financial Accountability Ratings, clarifies the criteria for open-enrollment charter school financial indicators. Specifically, adopted new subsection (b) clarifies issues related to indicators and requirements that apply at the charter holder and/or charter school level.

The adopted amendment to 19 TAC §109.1005, Reporting, clarifies the timing of certain required comparisons that must be included in the annual financial management report and states that the annual financial management report prepared by a school district or open-enrollment charter school must also include other written documentation of employment for a superintendent where no contract exists. In response to public comment, subsection (b)(2)(A) was revised at adoption to clarify that the purpose of this section of the report is to provide details on all compensation and benefits paid to a superintendent. Subsection (b)(2)(B) was also revised at adoption to add clarifying language to include payments made on behalf of the superintendent and trustees. Additionally, new subsection (b)(2)(F) adds to the annual financial management report a summary schedule of the data submitted using the electronic-based program developed under the financial solvency provisions of the TEC, §39.0822. Revisions to subsection (c) further clarify the publication requirements for open-enrollment charter schools related to the public hearing notice required for the annual financial management report hearing.

In addition, 19 TAC Chapter 109, Subchapter AA, has been renamed and organized to include the addition of rules relating to financial accountability. The subchapter title has changed from "Commissioner's Rules Concerning Financial Accountability Rating System" to "Commissioner's Rules Concerning Financial Accountability." School FIRST rules are organized under new Division 1, Financial Accountability Rating System.

The adopted amendments update the worksheet and calculations used beginning in fiscal year 2010-2011 to report school district and open-enrollment charter school financial accountability information. TEA staff will continue to generate school district and open-enrollment charter school financial account-

ability ratings based on data submitted by school districts and open-enrollment charter schools. TEC, §39.082, specifically requires open-enrollment charter schools to follow the same reporting requirements related to the financial accountability rating system that school districts have followed for several years. The adopted amendments also requires a school district and open-enrollment charter school to include in its annual financial management report a summary schedule of data submitted to support the financial solvency provisions of the TEC, §39.0822. The adopted amendments have no new locally maintained paperwork requirements.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 22, 2010, and ended November 22, 2010. Following is a summary of public comments received and corresponding agency responses regarding the proposed amendments to 19 TAC Chapter 109, Budgeting, Accounting, and Auditing, Subchapter AA, Commissioner's Rules Concerning Financial Accountability Rating System.

§109.1002, Financial Accountability Ratings

Comment: Concerning proposed Figure: 19 TAC §109.1002(f), an administrator from Round Rock Independent School District stated that the rating worksheet explanation for Indicator 9 erroneously includes the words "per student" in reference to property taxes collected per penny of tax effort.

Agency Response: The agency agrees and has removed the "per student" reference from the explanation for Indicator 9 in Figure: 19 TAC §109.1002(f). The agency notes that, although the "per student" phrase has been referenced in the worksheet explanation for a number of years, the actual calculation has been performed correctly.

Comment: Concerning proposed Figure: 19 TAC §109.1002(f), the Texas Classroom Teachers Association (TCTA) commented that, for Indicator 16 (student-to-teacher ratio), the rule should clarify that the definition for the term "teacher" is the same as TEC, §5.001.

Agency Response: The agency disagrees. TEC, §5.001, defines a classroom teacher as an educator who is employed by a school district and who, not less than an average of four hours each day, teaches in an academic instructional setting or a career and technology instructional setting. The term does not include a teacher's aide or a full-time administrator. In the Financial Integrity Rating System of Texas (FIRST), the number of teachers is calculated from PEIMS Code Table C021 Role-ID as defined in the FIRST software application. More specifically, a teacher is defined as a professional employee who is required to hold a valid teacher certificate or permit in order to perform some type of instruction to students. Permanent substitute teachers are also included in this total. The agency has determined that, for the purposes of financial accountability, the teacher information reflected in PEIMS provides the most accurate reflection of a district's financial obligation.

Comment: Concerning proposed Figure: 19 TAC §109.1002(f) and Figure: 19 TAC §109.1002(g) and the indicators for teacher and staff ratios, the TCTA commented that it applauds the fact that the proposed rating worksheet requires more specificity than past renditions in that it awards points based on specified numerical ranges but noted that the rating system still does not require the district to identify specifics should the district fall outside the low-to-high range. The TCTA stated that the district should be required to identify specific statistics should it fall outside the low-to-high range.

Agency Response: The agency agrees in part and disagrees in part. The agency agrees that the numerical ranges reflected in the ratings worksheet provide for additional specificity in the calculation results. However, the agency disagrees that the rating system report is the appropriate method for disseminating additional district-specific statistics or explanatory information related to the calculation result. When FIRST results are published, each indicator displays the result of a district's calculation. The calculation for this ratio awards points based on specific numerical ranges. Additional explanatory information is not requested from a district at the point of rating assignment. However, the financial management report procedure under TEC, §39.083, requires a district to hold a public meeting to discuss its FIRST results compared to both the state standard and the district's performance for the prior year. Furthermore, if a district fails School FIRST, it is required to submit a corrective action plan to the agency to explain how it will address each indicator contributing to the district's School FIRST failure. The public hearing and corrective action plan processes offer an opportunity for the district to provide more detailed statistics and explanatory information.

Comment: Concerning proposed Figure: 19 TAC §109.1002(f), the TCTA commented that, in regard to Indicator 18 (testing for the general fund balance to fall within 50% and 150% of the optimum fund balance), a measure should be created that would not penalize a district for spending more than 10% of its fund balance on payroll/operating costs if the district has a fund balance in excess of 150% of the optimum level on payroll or other operating costs, making it perhaps appropriate to spend some portion of the fund balance on payroll or other operating costs.

Agency Response: The agency disagrees. Unless a district has a plan to accumulate funds for large capital expenditures, a fund balance far in excess of the optimum may indicate that the district's tax rate is too high or reflect a lack of internal financial planning and monitoring of the district's resources. Furthermore, the agency notes that this is not a critical indicator that results in automatic failure of School FIRST. Therefore, a district could earn fewer than five points on this indicator and still receive an acceptable, or higher, School FIRST rating.

Comment: Concerning proposed §109.1002(g), the Texas Charter Schools Association (TCSA) recommended that application of the rules be postponed for another year to 2011-2012, stating that member schools are entitled to timely advanced notice before the imposition of regulatory standards that will impact the school's accountability rating, accreditation status, and, ultimately, the status of the school's contract with the state. The TCSA further commented that schools already have adopted their budgets and spending patterns for 2010-2011, making compliance with the newly proposed standards potentially more difficult and unnecessarily burdensome.

Agency Response: The agency disagrees. The proposed standards were posted for public comment on October 22, 2010, and have been presented to charter school stakeholders in a number of forums before and since that time. Therefore, a charter holder or charter school has had, and will have, sufficient time to make any necessary budget adjustments for the 2010-2011 fiscal year. Since the School FIRST for Charter Schools indica-

tors are based primarily on standard non-profit financial ratios, a non-profit organization with adequate financial practices could obtain a rating of Standard Achievement or higher when related 2012 ratings are issued.

Comment: Concerning proposed Figure: 19 TAC §109.1002(g), an outside contractor commented that the explanatory statement for Indicator 7 included in the rating worksheet did not accurately reflect the calculation described for Indicator 7.

Agency Response: The agency agrees and has clarified the description for Indicator 7 in Figure: 19 TAC §109.1002(g) to match the actual calculation for Indicator 7.

Comment: Concerning proposed Figure: 19 TAC §109.1002(g), the TCSA commented that, since Indicator 14 sets a standard for each charter school's administrative cost ratio from 0.3614 to 0.1105, it seems to run afoul of the clear legislative mandate in TEC, §39.082(c), which says that the financial accountability rating system cannot include an indicator that requires the expenditure of at least 65 percent of a school's operating funds for instructional purposes. Further, the TCSA stated that the proposed ratios are not consistent with the spirit of the indirect cost allotments applied to federal programs monitored by the agency and should be deleted for these reasons.

Agency Response: The agency disagrees. The administrative cost ratio is a common method of reviewing whether a non-profit organization is primarily involved in activities that further the organization's exempt purposes. A higher administrative cost ratio could indicate that the entity is being operated for the benefit of private interests rather than its public mission. The federal program indirect cost allotments are meant to fund the portion of administrative costs that each federal program incurs. Furthermore, the agency notes that this is not a critical indicator that results in automatic failure of School FIRST. Therefore, a charter could earn fewer than five points on this indicator and still receive an acceptable, or higher, School FIRST rating.

Comment: Concerning proposed Figure: 19 TAC §109.1002(g), the TCSA noted that Indicator 15 asks about the ratio of students to teachers and further noted that the permissible ratio range varies according to the number of students enrolled in the charter school. The TCSA commented that this indicator is very likely aimed at determining a school's ability to finance its personnel costs for teachers but stated that, because charter schools are not required by law to adhere to any specific student-teacher ratio for classroom instruction, this indicator may threaten a charter school's ability to staff and assign teachers in the manner and in a ratio consistent with the school's mission and its efforts at innovation. The TCSA requested that Indicator 15, student-to-teacher ratio, be deleted. The TCSA stated that Indicator 16, which asks about the ratio of students to total staff, should be sufficient for the agency to determine the school's ability to finance its personnel costs.

Agency Response: The agency disagrees. Since the largest expense for most schools is teacher salaries, it is appropriate for the financial accountability system to review whether a charter school is able to finance this substantial obligation. Solely using Indicator 16, which involves a comparison of teachers to total staff, does not permit sufficient evaluation of teacher costs. Furthermore, the agency notes that Indicator 15 is not a critical indicator that results in automatic failure of School FIRST. Therefore, a charter could earn fewer than five points on this indicator and still receive an acceptable, or higher, School FIRST rating.

Comment: Concerning proposed §109.1002(i)(2)(C), which states that, "Errors by a district or open-enrollment charter school in recording data or submitting data through the TEA data collection and reporting system do not constitute a valid basis for appealing a preliminary rating," the TCSA commented that, for the sake of ensuring accurate financial data from charter schools, the agency should delete this rule or revise it to permit schools to correct their data if a bona fide data recording or submission error is discovered.

Agency Response: The agency disagrees. The majority of the data used in the FIRST rating system is produced in PEIMS, which has strict reporting deadlines and does not allow for additional submissions after the final deadline. Furthermore, superintendents are required to submit the electronic "Superintendent's Statement of Approval of Summary Report and Error Listing" (SAF) certifying the accuracy and authenticity of the data submitted for each PEIMS data collection. An open-enrollment charter school must have strong internal control procedures in place to ensure the accuracy of financial reports and to identify errors and omissions before submitting reports and data to the TEA.

§109.1003, Types of Financial Accountability Ratings

Comment: Concerning proposed §109.1003(a), the TCSA commented that it supports the addition of ratings for "Superior Achievement" and "Above Standard Achievement" to create the opportunity for open-enrollment charter schools with that level of achievement to be recognized. The TCSA further commented that the change creates parity in the rating system between open-enrollment charter schools and traditional school districts.

Agency Response: The agency agrees.

Comment: Concerning proposed §109.1003(b), the TCSA recommended that the commissioner add language stating that a financial accountability rating may be lowered based on the findings of an investigation conducted under TEC, Chapter 39, "but only if the ultimate findings of the investigation implicate a measurement, ratio, or other indicator set out in the ratings worksheet referenced under §109.1002(g)." The TCSA stated that this change was suggested so that the agency does not overreach its authority by assigning an accountability rating based on financial or non-financial information that has not previously been identified and published through measurements, ratios, and other indicators set out in the ratings worksheet.

Agency Response: The agency disagrees. It is appropriate for the agency to lower a financial accountability rating based on the findings of an investigation conducted under TEC, Chapter 39, as reasonably necessary to achieve the purposes of TEC, §39.051 and §39.052. If an investigation reveals material financial problems, and the rating issued is not reflective of the true financial position of the district, in accordance with the statute, it is appropriate for the commissioner to lower the district's financial accountability rating in response to the findings of the investigation. Furthermore, in accordance with 19 TAC §97.1031 and §97.1033, a district will have the opportunity to respond to preliminary investigative findings before a final report is issued or a financial accountability rating is impacted. A school then has the opportunity to appeal a financial accountability rating in accordance with the appeal process outlined in §109.1002.

§109.1005, Reporting

Comment: Concerning proposed §109.1005(b)(2)(A) and the financial management report to be prepared under this section,

the TCSA commented that it is unclear what kind of documentation might suffice for "other written documentation of employment where no contract exists" with the school superintendent and urged that the rules be more explicit about what documents might be sufficient for this purpose.

Agency Response: The agency disagrees that it is necessary or appropriate for the rule to contain an explicit list of documents. The annual financial management report is required to disclose all compensation and benefits for a superintendent. Due to the various arrangements for superintendent compensation in a charter school, it would not be practical to provide a detailed list of methods of documentation. However, in response to the comment, clarifying language has been added to §109.1005(b)(2)(A) to describe the purpose of reporting the information.

Comment: Concerning proposed §109.1005(b)(2)(B), an individual commented that additional instructions to schools should be given so that it is clear that total expenditures for the superintendent and trustees should be reported in the financial management report, including items paid on behalf of the superintendent or the trustees directly by the school and not just direct reimbursements.

Agency Response: The agency agrees. The language directing schools to report all reimbursements regardless of the manner of payment appears on the sample spreadsheet provided on the agency website but not within the rules. Therefore, the agency has added clarifying language to §109.1005(b)(2)(B) to add a reference to expenditures paid on behalf of a superintendent or board member.

The amendments are adopted under the Texas Education Code, §39.085, which requires the commissioner of education to adopt rules as necessary for the implementation and administration of financial accountability rating systems for school districts and open-enrollment charter schools.

The amendments implement the TEC, §§39.081-39.085.

*§109.1002. Financial Accountability Ratings.*

(a) In accordance with Texas Education Code (TEC), Chapter 39, Subchapter D, each school district and open-enrollment charter school must be assigned a financial accountability rating by the Texas Education Agency (TEA). The specific procedures for determining financial accountability ratings will be established annually by the commissioner of education and communicated to all school districts and open-enrollment charter schools.

(b) For fiscal years 2002-2003, 2003-2004, 2004-2005, and 2005-2006, each financial accountability rating of a school district is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "School FIRST - Rating Worksheet," effective May 2003.
Figure: 19 TAC §109.1002(b) (No change.)

(c) For fiscal years 2006-2007 and 2007-2008, the financial accountability rating of a school district is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "School FIRST - Rating Worksheet Effective August 2006." On this form, Indicator 13 entitled, "Was The Percent Of Operating Expenditures Expended For Instruction More Than or Equal to 65%?" was phased in over a three-year period, as follows.
Figure: 19 TAC §109.1002(c) (No change.)

(1) For fiscal year 2006-2007, the indicator was "Was The Percent Of Operating Expenditures Expended For Instruction More Than or Equal to 55%?"

(2) For fiscal year 2007-2008, the indicator was "Was The Percent Of Operating Expenditures Expended For Instruction More Than or Equal to 60%?"

(3) For fiscal year 2008-2009 and beyond, the indicator was repealed.

(d) For fiscal years 2008-2009 and 2009-2010, the financial accountability rating of a school district is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "School FIRST - Rating Worksheet Dated March 2010."
Figure: 19 TAC §109.1002(d) (No change.)

(e) For fiscal years 2008-2009 and 2009-2010, the financial accountability rating of an open-enrollment charter school is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "Charter School - School FIRST - Rating Worksheet Dated March 2010."
Figure: 19 TAC §109.1002(e) (No change.)

(f) Beginning with fiscal year 2010-2011, the financial accountability rating of a school district is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "School FIRST - Rating Worksheet Dated December 2010."
Figure: 19 TAC §109.1002(f)

(g) Beginning with fiscal year 2010-2011, the financial accountability rating of an open-enrollment charter school is based on its overall performance on certain financial measurements, ratios, and other indicators established by the commissioner of education in the financial accountability rating form provided in this subsection entitled "School FIRST for Charter Schools - Rating Worksheet Dated December 2010."
Figure: 19 TAC §109.1002(g)

(h) A financial accountability rating by a voluntary association is a local option of the district or open-enrollment charter school, but it does not substitute for a financial accountability rating by the TEA.

(i) The TEA will issue a preliminary financial accountability rating to a school district or open-enrollment charter school within 150 days of its complete financial data being made available to the TEA staff. The financial accountability rating for a particular year will always be based on complete and audited financial data from the previous fiscal year given the availability of the data. For example, the final 2010 School FIRST rating issued in August 2010 is based on complete and audited financial data for the 2008-2009 fiscal year and is the financial accountability rating for the 2009-2010 school year for the purposes of §97.1055 of this title (relating to Accreditation Status).

(1) The issuance of the preliminary or final rating will not be delayed if a district or open-enrollment charter school fails to meet the statutory deadline for submitting the annual financial and compliance report. Instead, a rating of Suspended-Data Quality under §109.1003(a)(5) of this title (relating to Types of Financial Accountability Ratings) will be issued.

(2) A district or open-enrollment charter school may submit a written appeal requesting that the TEA review a preliminary rat-

ing if the preliminary rating was based on a data error solely attributable to the TEA's review of the data for any of the indicators.

(A) The TEA office responsible for financial audits must receive the appeal no later than 30 days after the TEA's release of the preliminary rating, and the appeal must include substantial evidence that supports the district's or open-enrollment charter school's position.

*(i)* Only appeals that would result in a change of the preliminary rating will be considered.

*(ii)* The TEA staff will review information submitted by the district or open-enrollment charter school to validate the statements made to the extent possible. The TEA will examine all relevant data.

*(iii)* The TEA staff will prepare a recommendation and forward it to an external panel for review. This review panel will provide independent oversight to the appeals process.

*(iv)* The external review panel will examine the appeal, supporting documentation, staff research, and the staff recommendation. The review panel will determine its recommendation.

*(v)* The external review panel's recommendation will be forwarded to the commissioner.

*(vi)* The commissioner will make a final decision in accordance with the timeline specified in subparagraph (E) of this paragraph.

(B) Appeals received 31 days or more after the TEA issues a preliminary rating will not be considered.

(C) Errors by a district or open-enrollment charter school in recording data or submitting data through the TEA data collection and reporting system do not constitute a valid basis for appealing a preliminary rating.

(D) A district that is the fiscal agent for a shared services arrangement (SSA) and has the staff of the SSA on its payroll may appeal the two indicators related to student-to-teacher and student-to-staff ratios if it fails these indicators due to the number of staff that are SSA staff. The district must provide the TEA with the number of staff that are employees of the district and the number of staff that are part of the SSA. This adjustment should not be a factor for an open-enrollment charter school that is a fiscal agent since the SSA reporting requirements are different than a school district.

(E) If the TEA receives an appeal of a preliminary rating, a final rating will be issued to the school district or open-enrollment charter school no later than 45 days after the appeal has been received by the TEA.

(F) If the TEA does not receive an appeal of a preliminary rating, the preliminary rating automatically becomes a final rating on the 31st day after issuance of the preliminary rating.

(G) A final rating issued by the TEA pursuant to this section may not be appealed under the TEC, §7.057, or any other law or rule.

*§109.1005. Reporting.*

(a) Each school district and open-enrollment charter school is required to report information and financial accountability ratings to parents and taxpayers by implementing the following reporting procedures.

(1) Each school district and open-enrollment charter school is required to prepare and distribute an annual financial management report in accordance with subsection (b) of this section.

(2) The public must be provided an opportunity to comment on the report at a public hearing in accordance with subsection (c) of this section.

(b) The annual financial management report prepared by the school district and open-enrollment charter school must include:

(1) a description of its financial management performance based on a comparison, provided by the Texas Education Agency (TEA), of its performance on the indicators established by the commissioner of education and reflected in §109.1002 of this title (relating to Financial Accountability Ratings). The report will contain information that discloses:

(A) state-established standards; and

(B) the district's or open-enrollment charter school's financial management performance under each indicator for the current and previous year's financial accountability ratings;

(2) any descriptive information required by the commissioner of education, including:

(A) a copy of the superintendent's current employment contract or other written documentation of employment where no contract exists. The purpose of this disclosure is to report all compensation and benefits paid to the superintendent. The school district or open-enrollment charter school may publish the superintendent's employment contract on the school district's or open-enrollment charter school's Internet site in lieu of publication in the annual financial management report;

(B) a summary schedule for the fiscal year (12-month period) of expenditures paid on behalf of and/or total reimbursements received by the superintendent and each board member, including transactions resulting from use of the school district's or open-enrollment charter school's credit card(s) to cover expenses incurred by the superintendent and each board member. The summary schedule shall separately report reimbursements for meals, lodging, transportation, motor fuel, and other items (the summary schedule of total reimbursements is not to include reimbursements for supplies and materials that were purchased for the operation of the school district or open-enrollment charter school);

(C) a summary schedule for the fiscal year of the dollar amount of compensation and/or fees received by the superintendent from another school district or open-enrollment charter school or any other outside entity in exchange for professional consulting and/or other personal services. The schedule shall separately report the amount received from each entity;

(D) a summary schedule for the fiscal year of the total dollar amount by the executive officers and board members of gifts that had an economic value of $250 or more in the aggregate in the fiscal year. This reporting requirement only applies to gifts received by the school district's or open-enrollment charter school's (or charter holder's) executive officers and board members (and their immediate family as described by Government Code, Chapter 573, Subchapter B, as a person related to another person within the first degree by consanguinity or affinity) from an outside entity that received payments from the school district or open-enrollment charter school (or charter holder) in the prior fiscal year, and gifts from competing vendors that were not awarded contracts in the prior fiscal year. This reporting requirement does not apply to reimbursement of travel-related expenses by an outside entity when the purpose of the travel is to investigate or explore matters directly related to the duties of an executive officer or board member, or matters related to attendance at education-related conferences and seminars whose primary purpose is to provide continuing education (this exclusion does not apply to trips for entertainment-re-

lated purposes or pleasure trips). This reporting requirement excludes an individual gift or a series of gifts from a single outside entity that had an aggregate economic value of less than $250 per executive officer or board member;

(E) a summary schedule for the fiscal year of the dollar amount by board member for the aggregate amount of business transactions with the school district or open-enrollment charter school (or charter holder). This reporting requirement is not to duplicate the items disclosed in the summary schedule of reimbursements received by board members; and

(F) a summary schedule of the data submitted using the electronic-based program developed under the financial solvency provisions of Texas Education Code, §39.0822; and

(3) any other information the board of trustees of the district or open-enrollment charter school determines to be useful.

(c) The board of trustees of each school district or open-enrollment charter school shall hold a public hearing on the annual financial management report within two months after receipt of a final financial accountability rating (including a final rating of Suspended--Data Quality). The public hearing is to be held at a location in the district's or open-enrollment charter school's facilities. The board shall give notice of the hearing to owners of real property in the geographic boundaries of the district or open-enrollment charter school and to parents of district or open-enrollment charter school students. In addition to other notice required by law, notice of the hearing must be provided:

(1) to a newspaper of general circulation in the geographic boundaries of the district or each campus of an open-enrollment charter school once a week for two weeks prior to holding the public meeting, providing the time and place where the hearing is to be held. The first notice in the newspaper may not be more than 30 days prior to or less than 14 days prior to the public meeting. If there is not a newspaper published in the county in which the district's central administration office is located or within the geographic boundaries of a campus of an open-enrollment charter school, then the notice is to be published in the county nearest the county seat of the county in which the district's central administration office is located or in which the campus of the open-enrollment charter school is located; and

(2) through electronic mail to media serving the district or open-enrollment charter school.

(d) At the hearing, the annual financial management report shall be disseminated to the district's or open-enrollment charter school's parents and taxpayers that are in attendance.

(e) The annual financial management report is to be retained in the district or open-enrollment charter school for at least a three-year period after the public hearing and will be made available to parents and taxpayers upon request.

(f) A corrective action plan is to be filed with the TEA by each school district or open-enrollment charter school that received a rating of Substandard Achievement or Suspended--Data Quality. The corrective action plan, which is to be prepared in accordance with instructions from the commissioner of education, is to be filed within one month after the district's or open-enrollment charter school's public hearing. The commissioner of education may require certain information in the corrective action plan to address the factor(s) that may have contributed to a district's or open-enrollment charter school's rating of Substandard Achievement or Suspended--Data Quality.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-201100159
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
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For further information, please call: (512) 475-1497

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# TITLE 22. EXAMINING BOARDS

## PART 17. TEXAS STATE BOARD OF PLUMBING EXAMINERS

### CHAPTER 361. ADMINISTRATION

### SUBCHAPTER A. GENERAL PROVISIONS

**22 TAC §361.1**

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §361.1 (Board Rule §361.1), concerning Definitions, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10001).

REASONED JUSTIFICATION. The amendments to §361.1 are adopted in response to the passage of Senate Bill (SB) 1410 and SB 1354, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Texas Occupations Code Chapter 1301 (Plumbing License Law) by SB 1410, including a definition of Responsible Master Plumber and requirements for persons licensed, endorsed, and registered by the Board to perform plumbing work under the general supervision of a Responsible Master Plumber.

The adopted amendments also reflect the language of SB 1410 and SB 1354 by adding language to allow a person to hold a Plumbing Inspector license if the person is employed or contracted by a state agency.

The amendments include language from SB 1354 which requires a Field Representative of the Board to be licensed by the Board as a plumber.

The adopted amendments add the terms "distribute" and "circulate" to the definition of "Plumbing" and "design" to the definition of "Master Plumber," as required by SB 1354.

As required by SB 1410, the adopted amendments remove the term "who secures permits for plumbing work" from the definition of "Master Plumber," because SB 1410 grants such authority to a "Responsible Master Plumber."

The adopted amendments reflect requirements of SB 1354 for mandatory annual training, which is equivalent to Continuing Professional Education, for those who wish to renew a Drain Cleaner, Drain Cleaner-Restricted Registrant or Residential Utilities Installer registration.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY. The amendments to §361.1 are adopted under and affect the Plumbing License Law, as

amended by the 81st Legislature, §§1301.251, 1301.002, 1301.203, 1301.405, and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.002 provides definitions of licenses, endorsements and registrations issued by the Board. Section 1301.203 describes a Board Field Representative and §1301.405 requires annual training, which is equivalent to Continuing Professional Education, for the renewal of certain registrations. The amendments to Board Rule §361.1 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
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For further information, please call: (512) 936-5224

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## CHAPTER 363. EXAMINATIONS

### 22 TAC §363.1

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §363.1 (Board Rule §363.1), concerning Qualifications, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10006).

REASONED JUSTIFICATION. The amendments to §363.1 are adopted in response to the passage of Senate Bill (SB) 1410, 81st Regular Legislative Session. Texas Occupations Code §1301.3565 was added to the Texas Occupations Code Chapter 1301 (Plumbing License Law) by SB 1410, which provides for a new category of license endorsement for the installation of multipurpose residential fire protection sprinkler systems. The Board satisfied a requirement of §1301.3565 by approving criteria for a training program for persons who wish to qualify for the Multipurpose Residential Fire Protection Sprinkler Specialist Endorsement. Section 1301.3565 also allows a Plumbing Inspector who meets the requirements of the Board to inspect multipurpose residential fire protection sprinkler installations.

Board Rule §363.1(f) requires 500 hours of training or experience in the plumbing industry of an applicant for the Plumbing Inspector examination, who is not licensed by the Board, not licensed by the state as a professional engineer or architect or not licensed in another state as a plumbing inspector. Section 363.1(f) lists various methods for such an applicant to accumulate credit for the 500 hours of plumbing related training.

The adopted amendments will provide such applicants with an additional option toward accumulating the required 500 hours of plumbing related training or experience. The adopted amendments will allow 100 hours of credit for the successful completion of a Board approved Multipurpose Residential Fire Protection Sprinkler Specialist Endorsement training program. The 100 hours of credit will serve to encourage such applicants to gain knowledge of multipurpose residential fire protection sprinkler systems by completing the training program.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY. The amendments to §363.1 are adopted under and affect the Plumbing License Law, as amended by the 81st Legislature, §1301.251, §1301.3565 and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.3565 allows a Plumbing Inspector who meets the requirements of the Board to inspect multipurpose residential fire protection sprinkler installations. The amendments to §363.1 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill (HB) 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Robert L. Maxwell
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For further information, please call: (512) 936-5224

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### 22 TAC §363.12

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §363.12 (Board Rule §363.12), concerning Training Programs for Journeyman Plumber and Tradesman Plumber-Limited License Applicants, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10009).

REASONED JUSTIFICATION. The training requirements specified in current §363.12 include completion of the Occupational Safety and Health Administration (OSHA) 10-Hour Outreach Training for the construction industry. Section 363.12 specifies the number of hours required for each segment of the OSHA 10-Hour Outreach Training, including one hour specified for the segment titled "Introduction to OSHA." The amendments to §363.12 are adopted in response to a change implemented by OSHA in the specific number of hours required for the segment titled "Introduction to OSHA" from one hour to two hours.

In order to eliminate the current conflict between the OSHA requirements and the requirements of §363.12, the Board adopts to eliminate the specific hour requirements listed in §363.12 for each segment of the OSHA training, while keeping the language which requires applicants to complete the OSHA 10-Hour Outreach program related to the construction industry. This adoption will serve to eliminate not only the current conflict, but also any possible future conflict regarding the specific number of hours required for each segment. The result will be that Board approved Course Instructors will have the ability to follow both OSHA guidelines and the requirements of §363.12 harmoniously when providing the OSHA 10-Hour Outreach Training to applicants. In this manner, the applicant who successfully completes the training will receive Board credit for completing the training required in §363.12 and also qualify for a certification from OSHA for completing the 10-Hour Outreach Training.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY. The amendments to §363.12 are adopted under and affect the Plumbing License Law, as amended by the 81st Legislature, §1301.251, §1301.354 and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.354 sets forth the training requirements for applicants for the Journeyman Plumber and Tradesman Plumber-Limited examinations. The amendments to §363.12 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Robert L. Maxwell
Executive Director
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## CHAPTER 365. LICENSING AND REGISTRATION

### 22 TAC §365.2

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §365.2 (Board Rule §365.2), concerning Exemptions, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10012).

REASONED JUSTIFICATION. The amendments are adopted in response to the passage of Senate Bill (SB) 1354, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Texas Occupations Code Chapter 1301 (Plumbing License Law) by SB 1354 to §1301.052 and §1301.053.

Section 1301.052 describes certain plumbing work which is exempted from licensing requirements, based on the type and location of plumbing work. Section 1301.052 was amended to add the terms "repair" and "remodeling" to the existing term "new Construction," as the types of plumbing which require a license issued by the Board, regardless of where the plumbing is performed. Section 1301.052, as amended, provides certain exemptions to the licensing requirements for other plumbing work which is not performed in conjunction with new construction, repair or remodeling. The amendments to §365.2 reflect the amendments made to §1301.052 of the Plumbing License Law.

Section 1301.053 was amended to exclude "installation and service work on water heaters" from plumbing which may be performed by an appliance dealer or an employee of an appliance dealer who does not hold a license issued by the Board. The amendments to §365.2 also reflect the amendments made to §1301.053 of the Plumbing License Law.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY. The amendments to §365.2 are adopted under and affect Title 8, Chapter 1301, Occupations Code, as amended by the 81st Legislature ("Plumbing License Law" or "Law"), §§1301.251, 1301.052, 1301.053 and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.052 describes certain plumbing work which is exempted from licensing requirements, based on the type and location of plumbing work. Section 1301.053 describes certain plumbing work incidental to professions which may be performed without a license. The amendments to §365.2 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 936-5224

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### 22 TAC §365.5

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §365.5 (Board Rule §365.5), concerning Renewals, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10013).

REASONED JUSTIFICATION. The amendments to §365.5 are adopted in response to the passage of Senate Bill (SB) 1354, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Chapter 1301 of the Texas Occupations Code (Plumbing License Law) by SB 1354, including a new section of the Plumbing License Law, §1301.405, which requires at least six hours of annual mandatory training for the renewal of Drain Cleaner, Drain Cleaner-Restricted Registrant and Residential Utilities Installer registrations. The language in §1301.405 closely resembles the language in existing §1301.404, which requires annual continuing professional education for the renewal of licenses issued by the Board. At its July 13, 2009 Board meeting, the Board voted to accept the current Continuing Professional Education program required in §1301.404 and detailed in §365.14 to meet the new requirements in §1301.405 for renewal of the affected registrations.

The amendments to §365.5 simply add the names of the affected registrations to the list of licenses which require at least six hours of Continuing Professional Education annually in order to renew the registrations and licenses.

No comments were received regarding the proposed rule amendment.

STATUTORY AUTHORITY. The amendments to §365.5 are adopted under and affect the Plumbing License Law §§1301.251, 1301.404, 1301.405, and Board Rule §365.6 and §365.14. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.404 requires at least six hours annually of continuing professional education for the renewal of licenses issued by the Board. Section 1301.405 requires at least six hours annually of mandatory training for certain registrations issued by the Board. Section 365.6 defines the terms under which licenses, endorsements and registrations issued by the Board expire. Section 365.14 provides the rules under which the Continuing Professional Education programs are carried out. The amendments to §365.5 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill (HB) 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if a adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by this adopted amendment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## 22 TAC §365.6

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §365.6 (Board Rule §365.6), concerning Expirations, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10014).

REASONED JUSTIFICATION. The amendments to §365.6 are adopted in response to the passage of Senate Bill (SB) 1354, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Chapter 1301 of the Texas Occupations Code (Plumbing License Law) by SB 1354, including a new §1301.405, which requires at least six hours of annual mandatory training for the renewal of Drain Cleaner, Drain Cleaner-Restricted Registrant and Residential Utilities Installer registrations. The language in §1301.405 closely resembles the language in existing §1301.404, which requires annual continuing professional education for the renewal of licenses issued by the Board. At its July 13, 2009 Board meeting, the Board voted to accept the current Continuing Professional Education program required in §1301.404 and detailed in §365.14 to meet the new requirements in §1301.405 for renewal of the affected registrations.

The amendments to §365.6 simply add the names of the affected registrations to the list of licenses which require at least six hours of Continuing Professional Education annually in order to renew the registrations and licenses.

No comments were received regarding the proposed rule amendment.

STATUTORY AUTHORITY. The amendments to §365.6 are adopted under and affect the Plumbing License Law, as amended by the 81st Legislature, specifically §§1301.251, 1301.404, 1301.405, and Board Rule §365.5 and §365.14. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.404 requires at least six hours annually of continuing professional education for the renewal of licenses issued by the Board. Section 1301.405 requires at least six hours annually of mandatory training for certain registrations issued by the Board. Section 365.5 sets forth the requirements for renewal of licenses, endorsements and registrations issued by the Board. Section 365.14 provides the rules under which the Continuing Professional Education programs are carried out. The amendments to §365.6 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill (HB) 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by this adopted amendment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Robert L. Maxwell
Executive Director
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For further information, please call: (512) 936-5224

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**22 TAC §365.14**

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §365.14 (Board Rule §365.14), concerning Continuing Professional Education Programs, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10015).

REASONED JUSTIFICATION: The amendments to §365.14 are adopted in response to the passage of Senate Bill (SB) 1354, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Texas Occupations Code Chapter 1301 (Plumbing License Law) by SB 1354, including Plumbing License Law §1301.405, which requires at least six hours of annual mandatory training for the renewal of Drain Cleaner, Drain Cleaner-Restricted Registrant and Residential Utilities Installer registrations. The language in §1301.405 closely resembles the language in existing §1301.404, which requires annual continuing professional education for the renewal of licenses issued by the Board. At its July 13, 2009 Board meeting, the Board voted to accept the current Continuing Professional Education program required in §1301.404 and detailed in §365.14 to meet the new requirements in §1301.405 for renewal of the affected registrations.

The amendments to §365.14 add the names of the affected registrations to the list of licenses which require at least six hours of Continuing Professional Education annually in order to renew expired registrations and licenses. The amendments also add words and terms referencing the applicable registrations necessary to carry out the new requirements.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY: The amendments to §365.14 are adopted under and affect the Plumbing License Law §§1301.251, 1301.404, and 1301.405, and Board Rule §365.5 and §365.6. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.404 requires at least six hours annually of continuing professional education for the renewal of licenses issued by the Board. Section 1301.405 requires at least six hours annually of mandatory training for certain registrations issued by the Board. Section 365.5 sets forth the renewal requirements for licenses, endorsements and registrations issued by the Board. Section 365.6 sets forth the terms under which licenses, registrations and endorsements issued by the Board expire. The amendments to §365.14 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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## CHAPTER 367. ENFORCEMENT

**22 TAC §367.7**

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §367.7 (Board Rule §367.7), concerning Violations of Standards and Practices, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10020).

REASONED JUSTIFICATION: The amendments to §367.7 are adopted in response to the passage of Senate Bill 1410, 81st Regular Legislative Session. The adopted amendments reflect revisions made to Chapter 1301 of the Texas Occupations Code (Plumbing License Law) by SB 1410, including §§1301.002, 1301.451, 1301.452, 1301.5045 and 1301.707.

The adopted amendments also clarify the requirements of Board Rule §367.7 by eliminating an obsolete reference to Chapter 365, relating to licensing and registration. Further clarification is adopted by adding language which identifies a civil penalty as being that described in §1301.507 of the Plumbing License Law.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY: The amendments to §367.7 are adopted under and affect Plumbing License Law §1301.251, §1301.002, Subchapter I, Subchapter J, Subchapter N, Board Rules Chapter 367, and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.002 defines a plumbing inspector as a person who must be employed or contracted with a political subdivision. Subchapter I sets forth disciplinary powers of the Board and grounds for disciplinary action. Subchapter J describes other penalties and enforcement provisions. Subchapter N sets forth the procedures for the imposition of administrative penalties explains legal rights under law afforded to alleged violators. Chapter 367 of the Board Rules sets forth enforcement provisions, disciplinary procedures, requirements for persons who perform plumbing, and legal rights afforded to alleged violators of the Plumbing License Law and Board Rules. The amendments to §367.7 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100147
Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
Effective date: February 3, 2011
Proposal publication date: November 12, 2010
For further information, please call: (512) 936-5224

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**22 TAC §367.10**

The Texas State Board of Plumbing Examiners (Board) adopts amendments to 22 TAC §367.10 (Board Rule §367.10), concerning Administrative Penalty, without changes to the proposed text as published in the November 12, 2010, issue of the *Texas Register* (35 TexReg 10021).

REASONED JUSTIFICATION: The amendments to §367.10 are adopted in response to the passage of Senate Bill 1410, 81st Regular Legislative Session. The adopted amendments combine certain provisions of the Plumbing License Law regarding administrative penalties found in Subchapter I, Disciplinary Procedures, Subchapter J, Other Penalties and Enforcement Provisions, and Subchapter N, Administrative Penalty, into one rule. This is in order to clarify the authority and procedures for the imposition of administrative penalties and ensure that all rights under law are afforded to an alleged violator.

No comments were received regarding the proposed rule amendments.

STATUTORY AUTHORITY: The amendments to §367.10 are adopted under and affect Title 8, Chapter 1301, Texas Occupations Code (Plumbing License Law), as amended by the 81st Legislature, Plumbing License Law §1301.251, Subchapter I, Subchapter J, Subchapter N, and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Subchapter I sets forth disciplinary powers of the Board and grounds for disciplinary action. Subchapter J describes other penalties and enforcement provisions. Subchapter N sets forth the procedures for the imposition of administrative penalties, and explains legal rights under law afforded to alleged violators. The amendments to §367.10 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, House Bill 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if an adopted rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these adopted amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

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Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
Effective date: February 3, 2011
Proposal publication date: November 12, 2010
For further information, please call: (512) 936-5224

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# TITLE 28. INSURANCE

## PART 1. TEXAS DEPARTMENT OF INSURANCE

### CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

### SUBCHAPTER S. CATASTROPHE RESERVE TRUST FUND

**28 TAC §§5.9901 - 5.9906**

The Commissioner of Insurance (Commissioner) adopts the repeal of Subchapter S, §§5.9901 - 5.9906, concerning the Catastrophe Reserve Trust Fund (CRTF) used by the Texas Windstorm Insurance Association (Association). The repeal is adopted without changes to the proposal as published in the July 23, 2010, issue of the *Texas Register* (35 TexReg 6489).

REASONED JUSTIFICATION. The repeal is necessary to incorporate the requirements set forth in these sections and the Insurance Code §2210.452 and §2210.453 into new §§5.4101, 5.4102, and 5.4111 - 5.4114. The Legislature has determined that the provision of windstorm and hail insurance is necessary for the economic welfare of the state and its inhabitants, and that the lack of such insurance would severely impede the orderly growth and development of the state. The Association was created by the Legislature and serves as a residual insurer of last resort for windstorm and hail insurance coverage (insurance coverage) in the catastrophe area designated by the Commissioner of Insurance under the Insurance Code §2210.005. The CRTF is a primary source for funding Association losses in excess of premium and other revenue. The repeal is necessary to update and incorporate the operation and use of the CRTF into the Association's plan of operation, and to create a more efficient rule structure by grouping these requirements with other related Association loss funding mechanisms in new §§5.4101, 5.4102, and 5.4111 - 5.4114. In conjunction with this adoption, the Department is adopting new §§5.4101, 5.4102, 5.4111 - 5.4114, 5.4121, 5.4131 - 5.4134, and 5.4141 - 5.4147, also published in this issue of the *Texas Register.*

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will allow for rules related to the operation and use of the CRTF to be updated and incorporated into the Association's plan of operation. This will create a more efficient rule structure by grouping these requirements with other related Association loss funding mechanisms in new §§5.4101, 5.4102, and 5.4111 - 5.4114.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department did not receive any comments on the published proposal.

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code Chapter 2210 and §36.001. The Insurance Code §2210.008 authorizes the Commissioner to adopt rules necessary to carry out the purposes of Insurance Code Chapter 2210. Section 2210.151 requires the Commissioner to adopt the Association's plan of operation as a rule. Section 2210.152(a)(1) requires the Association's plan of operation to provide for the efficient, economical, fair and nondiscriminatory administration of the Association. Section 2210.152(a)(2)(G) provides that the plan of operation may include other provisions considered necessary by the Department to implement the purposes of Chapter 2210. Section 2210.452 requires the Commissioner to adopt rules under which the Association makes payments to the CRTF including the net gain from operations of the Association at the end of each calendar year or policy year; and the procedure relating to the disbursement of money from the CRTF to the Association to fund the obligations of the CRTF under Chapter 2210, Subchapter B-1, Insurance Code. Section 2210.452(b) further provides that the comptroller, as custodian of the CRTF, shall administer the CRTF strictly and solely as provided by Chapter 2210, Insurance Code and Commissioner rules. Section 2210.452(d) provides that the CRTF may be terminated only by law and that on termination of the CRTF, all assets of the CRTF revert to the state to provide funding for the mitigation and preparedness plan established under the Insurance Code §2210.454. Section 2210.453 provides that the Association may purchase reinsurance that operates in addition to or in concert with the CRTF, public securities, financial instruments, and assessments authorized by Chapter 2210, Insurance Code. Section 36.001 authorizes the Commissioner of Insurance to adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2011.

TRD-201100137
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: February 2, 2011
Proposal publication date: July 23, 2010
For further information, please call: (512) 463-6327

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## CHAPTER 31. LIQUIDATION
## SUBCHAPTER B. AUDIT COVERAGES REQUIRED FOR THE RECEIVER AND SPECIAL DEPUTY RECEIVERS

### 28 TAC §§31.101 - 31.107

The Commissioner of Insurance (Commissioner) adopts the repeal of Subchapter B, §§31.101 - 31.107, concerning Audit Coverages Required for the Receiver and Special Deputy Receivers. The repeal is adopted without changes to the proposal as published in the December 3, 2010, issue of the *Texas Register* (35 TexReg 10597).

REASONED JUSTIFICATION. The repeal of this subchapter is necessary to implement legislative changes as a result of the enactment of revisions to the Insurance Code. The Insurance Code Article 21.28 §12(j) required the State Board of Insurance to adopt rules prescribing the audit coverage required for the receiver, special deputy receivers, and guaranty associations under specified provisions of the Insurance Code. Article 21.28 §12(j) required such rules to include provisions relating to scope, frequency, reporting requirements and costs of audits. Article 21.28 was repealed in the nonsubstantive Insurance Code revision, Acts 2005, 79th Legislature, Chapter 995, §9, effective September 1, 2005. Article 21.28 §12(j) was re-adopted as §442.451 in the nonsubstantive Insurance Code revision, Acts 2005, 79th Legislature, Chapter 727, §1, effective April 1, 2007, but §442.451 was later repealed by Acts 2007, 80th Legislature, Chapter 730, §3B.003, effective September 1, 2007.

House Bill (HB) 2157, enacted by the 79th Legislature, Regular Session, effective September 1, 2005, effectuated the Insurance Code §21A.355 which provides for an external audit of a receiver's books, which is similar to former Insurance Code Article 21.28 §12(g). Section 21A.355 was redesignated as §443.355 in the nonsubstantive Insurance Code revision, Acts 2007, 80th Legislature, Chapter 730, §3B.004(a)(1)(H), effective September 1, 2007. The Insurance Code §443.355 provides that the receivership court may, as it deems desirable, order audits to be made of the books of the receiver and a report of each audit shall be filed with the Commissioner and with the receivership court.

Under HB 2157, the authority to appoint a special deputy was retained under the Insurance Code Chapter 21A. Chapter 21A was redesignated as Chapter 443 in the nonsubstantive Insurance Code revision, Acts 2007, 80th Legislature, Chapters 730, §3B.004(a)(1), effective September 1, 2007. The Insurance Code §443.102(a) and §443.154(a) provides that the Commissioner, in his capacity as rehabilitator or liquidator, may appoint a special deputy to act on his behalf, and the special deputy serves at his pleasure. In accordance with the Insurance Code §443.102(e) and §443.154(x), the enumeration of the powers and authority of the Commissioner as rehabilitator or liquidator in these sections may not be construed as a limitation upon the rehabilitator or liquidator, nor may it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, to the extent necessary or appropriate.

Pursuant to the Insurance Code Chapter 443, the Commissioner, as rehabilitator or liquidator, has the inherent authority to audit a special deputy receiver acting on his behalf. Sections 31.101 - 31.107 are not needed to administer audits of special deputy receivers, and contain conditions that can restrict the ability of the rehabilitator or liquidator to conduct effective audits. Therefore, these rules are repealed.

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will result in increased flexibility for the rehabilitator or liquidator to conduct more effective audits of special deputy receivers.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department did not receive any comments on the published proposal.

STATUTORY AUTHORITY. The repeal is adopted pursuant to the Insurance Code §36.001, which authorizes the Com-

missioner of Insurance to adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 11, 2011.

TRD-201100106
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: January 31, 2011
Proposal publication date: December 3, 2010
For further information, please call: (512) 463-6327

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# PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

## CHAPTER 136. BENEFITS--VOCATIONAL REHABILITATION

**28 TAC §136.1, §136.2**

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §136.1 and §136.2 of this title (relating to Review of Employer Report of Injury and Registry of Private Providers of Vocational Rehabilitation Services). The amendments are adopted with no substantive changes to the proposed text published in the December 3, 2010, issue of the *Texas Register* (35 TexReg 10615). Section 136.1 is adopted without changes to the proposed text and will not be republished. Section 136.2 is adopted with changes to the proposed text and will be republished. A nonsubstantive change adding the acronyms for Licensed Master Social Worker (LMSW) and Licensed Clinical Social Worker (LCSW) was made to §136.2(b)(5). A nonsubstantive change was made to §136.2(c) for clarification purposes.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble, which in turn includes the rules. The preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, and the reasons why the Division agrees or disagrees with some of the comments and recommendations.

A request for a public hearing was not received. The public comment period closed January 3, 2011.

The *Registry of Private Providers of Vocational Rehabilitation Services* (Registry) is established by Labor Code §409.012(d), which states that a private provider of vocational rehabilitation services may register with the Division.

The Commissioner is authorized to establish acceptable credentials to be on the Registry by Labor Code §409.012(e), which provides that the Commissioner may require by rule that a private provider of vocational rehabilitation services maintain certain credentials and qualifications in order to provide services in connection with a workers' compensation claim. The Commissioner has established the list of credentials and qualifications to be on the Registry in §136.2 of this title. Under that authority, the Commissioner expands the list of acceptable credentials to provide a broader selection of vocational rehabilitation providers.

The amendments add "Licensed Master Social Worker" and "Licensed Clinical Social Worker" to the list of acceptable credentials, established by §136.2(b)(5) of this title, that an applicant must have to be on the Division's Registry. The current rule §136.2(b)(4) also requires an applicant to show education, training and experience in vocational rehabilitation.

The amendments also make nonsubstantive changes to conform to Labor Code requirements, current nomenclature, reformatting, and for clarification of terms.

The Registry is maintained by the Division and consists of providers who have applied to be on the Registry and have documented their qualifications. Individuals may apply to the Registry by submitting the Division's DWC-065 form to the Division. A submitted form is reviewed by Division staff for completeness and sufficiency of documentation. Applicants for the Registry must provide business contact information as specified by §136.2(b)(1) - (3) of this title, and must document that the applicant possesses the necessary experience in providing vocational rehabilitation services and credentials required by §136.2(b)(4) and (5) of this title. Applicants must also provide documentation that describes the evaluation, assessment, assistance, placement or support services specific to vocational rehabilitation services that they have available as a private provider. The Division may deny a person from inclusion on the Registry if they fail to meet any of the requirements outlined above. The Division reviews credentials on an annual basis and notifies registrants by mail of the need to re-register. The Division removes individuals from the Registry if a registrant fails to re-register.

The Registry may be utilized by an insurance carrier in order to locate individuals qualified to provide vocational rehabilitation services for injured employees. Insurance carriers are required to ensure any individual contracted to provide vocational services is qualified to do so under applicable provisions of the Labor Code, Title 5 and Division rules. Insurance carriers determine the use of a private provider of vocational rehabilitation services on a claim based on the individual circumstances associated with a claim.

Currently, there are 95 providers in the Registry. The names, addresses and telephone numbers of the providers in the Registry are available to the public on the Division's web site at *http://www.tdi.state.tx.us/wc/indexwc.html.*

Adopted §136.1 conforms the rule to Labor Code requirements and current nomenclature, replacing "commission" with "division", "employee" with "injured employee", "Texas Rehabilitation Commission" with "Department of Assistive and Rehabilitative Services" and "office" with "central office."

Adopted §136.2 conforms the rule to Labor Code requirements and current nomenclature.

Adopted amendments to subsection (a) replace "commission" with "division."

Adopted amendments to subsection (b) replace "commission" with "division" and "Austin office" with "the division's central office."

Adopted amendments to subsection (b)(5) are substantive and add "Licensed Master Social Worker (LMSW)" and "Licensed Clinical Social Worker (LCSW)" to the list of acceptable credentials that an applicant must possess to be on the Registry. The acronyms are added for clarification purposes.

Adopted amendments to subsection (c) replace "commission" with "division." The term "approved private provider" was substituted for the term "private provider who complies with the requirements of subsection (b) of this section." This is a nonsubstantive change in response to comments to clarify that the Division takes action on an application to ensure the application demonstrates compliance with §136.2(b), that application approval is not automatic.

Adopted amendments to subsection (d) replace "commission" with "division" and clarify that the Registry shall be posted on the Division's web site.

COMMENTS AND AGENCY RESPONSES

General

COMMENT: Several commenters expressed support for the proposed rule.

RESPONSE: The Division appreciates the support.

§136.2(b)(5)

COMMENT: Several commenters opposed the addition of Licensed Master Social Workers and Licensed Clinical Social Workers to the list of credentials to be on the Registry. The commenters stated that the current list of credentials is sufficient. The commenters stated that a Licensed Master Social Worker and Licensed Clinical Social Worker credentials do not necessarily qualify an individual to perform vocational rehabilitation services. The commenters stated that a vocational rehabilitation service provider should have courses and experience specific to vocational rehabilitation services, and the social worker degrees and licenses do not necessarily require it. The commenters stated that a provider of vocational rehabilitation services should have training in: vocational rehabilitation methods; theories and practices; practical and clinical experience in vocational rehabilitation settings and with vocational rehabilitation clients, work experience or formal training in disability issues, such as vocational aspects of disability; managed care and disability management concepts; business knowledge related to disability management; return-to-work intervention; vocational counseling; vocational assessment, job placement and job development; training in return-to- work coordination; researching specific industry and job domains; resume development; matching injured worker job capability with job descriptions; contacting different employers with different job tasks; coursework on medical, psychological and functional implications of disability; and vocational counseling and employment services. An existing credential, certified rehabilitation counselor (CRC), is available to individuals who have masters degrees in a field such as social work, work experience in the disability and employment arena, an 18 hour post-graduate advanced certificate in rehabilitation counseling, 36 months of work experience, at least 24 months of which must be under the supervision of a CRC, and passage of the CRC exam.

RESPONSE: The Division disagrees, but makes a clarification based on the comments. Every applicant for the Registry must meet all of the requirements of §136.2(b) of this title. These include §136.2(b)(4) of this title, which requires an applicant to provide a statement showing the applicant's education, training or experience in vocational rehabilitation and §136.2(b)(2) of this title, which requires the applicant to provide an informational brochure that describes the evaluation, assessment, assistance, placement or support services available from the applicant. An application will not automatically be approved. An applicant will not be approved solely on the basis of education, without specific training or experience in vocational rehabilitation. Each application will be processed in the same manner, in accordance with all of the provisions of §136.2 of this title. Only applications demonstrating compliance with §136.2(b) will be approved. Section 136.2(b)(6) has been clarified to state that only information on approved private providers will be included in the Registry. Each application will be evaluated on a case by case basis.

Licensed Master Social Workers and Licensed Clinical Social Workers are licensed by the State of Texas. Licensed Clinical Social Workers must have a masters or doctoral degree in Social Work and 3,000 hours of fulltime clinical employment experience. Licensed Master Social Workers must have a masters or doctoral degree in social work and have passed a national board exam. In order to practice independently, Licensed Master Social Workers' must complete 3,000 hours of board-approved supervised full time social work experience over a two year period, including 100 hours of face-to-face supervision with a board approved supervisor. This compares to the amount of supervised counseling experience that is required of a Licensed Professional Counselor, which is currently on the list of credentials for the Registry.

The Registry is primarily a resource to insurance carriers, who will have access to all of the background information provided by the applicant. The insurance carrier will then be able to select a provider whose background best suits their needs.

COMMENT: A commenter suggested adding Licensed Marriage and Family Therapist as an acceptable credential to be on the Registry. Their scope of practice includes career development and adjustment and rehabilitation therapy.

RESPONSE: The Division declines to make the change. While Marriage and Family Therapists may assist a person in treatment of an injury and psychological recovery from an injury, they do not necessarily provide the vocational counseling, vocational assessment, job placement and job development function that vocational rehabilitation services involve. The Division clarifies that the appropriate credentials for performing vocational rehabilitation services within the Texas workers' compensation system, as opposed to rehabilitation treatment, are reflected in or required by the rule and a summary of those credentials will be included in the registry.

§136.2(b)(6)

COMMENT: A commenter expressed concerns about §136.2(b)(6), the "related services" exception. The provision allows non-credentialed persons to perform services such as initial claimant intake, providing job search skills, verifying job search efforts, and serving as a liaison with potential employers. The commenter expressed concerns that the "related services" exception will result in an unacceptable erosion of the protec-

tion that only appropriately credentialed providers will perform vocational rehabilitation services.

RESPONSE: The Division declines to make a change. Each applicant for the Registry must state that only the registrant will perform vocational rehabilitation services under their registration. Furthermore, §136.2(b)(6) provides that if related services are performed by a non-credentialed person, the services must be performed under the direction of the registrant. The examples provided in the rule are primarily duties that are administrative in nature.

For, without changes: An individual, Property Casualty Insurers Association of America, National Association of Social Workers, Texas Chapter.

For, with changes: Office of Injured Employee Counsel, Texas Association for Marriage and Family Therapy.

Against: Americal Insurance Association, Texas Association for Rehabilitation Professionals and Providers of Services.

These amendments are adopted under the Labor Code §§409.012, 402.00116, 402.00111, 402.061, and 402.00128. Section 409.012 provides that the Commissioner may require by rule that a private provider of vocational rehabilitation services maintain certain credentials and qualifications in order to provide services in connection with a workers' compensation insurance claim and that a private provider of vocational rehabilitation services may register with the Division. Section 402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner and the authority to enforce Title 5, Labor Code, and other laws applicable to the Division or Commissioner. Section 402.00111 provides that the Commissioner shall exercise all executive authority, including rulemaking authority, under Title 5, Labor Code. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Workers' Compensation Act. Section 402.00128 vests general operational powers to the Commissioner including the authority to prescribe the form, manner and procedure for the transmission of information to the Division.

*§136.2. Registry of Private Providers of Vocational Rehabilitation Services.*

(a) The division shall maintain a registry of private providers of vocational rehabilitation services (registry). A private provider may apply to the division to be included in the registry.

(b) A private provider who wishes to be included in the registry shall complete a division approved registration form. The registration form shall be submitted in the form, format, and manner prescribed by the division to the division at the division's central office, signed by the provider, and include the following information:

(1) the private provider's name, business name (if applicable), business address, and telephone number;

(2) an informational brochure that describes the evaluation, assessment, assistance, placement, or support services available from the private provider;

(3) the locations where the private provider renders services;

(4) a statement showing the private provider's education, training, or experience in vocational rehabilitation;

(5) a statement showing the private provider is credentialed as a Licensed Professional Counselor (LPC), Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Certified Case manager (CCM), Certified Rehabilitation Counselor (CRC), Certified Vocational Evaluator (CVE), or Certified Disability Management Specialist (CDMS); and

(6) a statement that only the credentialed private provider of vocational rehabilitation services will perform vocational rehabilitation services, although related services (such as initial claimant intake, providing job search skills, verifying job search efforts, liaison with potential employers) may be performed by non-credentialed individuals under their direction.

(c) The division shall include in its registry, for a period of one year from the date the division enters the private provider's name in the registry, a summary of the information provided on the registration form of each approved private provider.

(d) The division shall provide a copy of the registry on the division's web site.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100160
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: February 3, 2011
Proposal publication date: December 3, 2010
For further information, please call: (512) 804-4703

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# TITLE 31. NATURAL RESOURCES AND CONSERVATION

## PART 1. GENERAL LAND OFFICE

### CHAPTER 15. COASTAL AREA PLANNING
### SUBCHAPTER A. MANAGEMENT OF THE BEACH/DUNE SYSTEM

**31 TAC §15.32**

The General Land Office (GLO) adopts amendments to §15.32, relating to Certification Status of Cameron County Dune Protection and Beach Access Plan, without changes to the proposed text as published in the November 26, 2010, issue of the *Texas Register* (35 TexReg 10423) and the text of the rule as amended will not be republished. The adopted amendment to §15.32 adds a new subsection (c) to certify as consistent with state law the amendments to the Cameron County Dune Protection and Beach Access Plan (Plan) that were adopted by the Cameron County Commissioners Court by order Number 201008049 on August 26, 2010.

Copies of the local government dune protection and beach access plan and any amendments to the Plan are available from Cameron County Parks and Recreation Department, 33174 State Park Road 100, South Padre Island, Texas 78597, phone number (956) 761-3700, and from the GLO's Archives

Division, Texas General Land Office, P.O. Box 12873, Austin, TX 78711-2873, phone number (512) 463-5277.

BACKGROUND

Pursuant to the Open Beaches Act (Texas Natural Resources Code, Chapter 61), the Dune Protection Act (Texas Natural Resources Code, Chapter 63), and the Beach/Dune Rules (31 TAC §§15.1 - 15.21), a local government with jurisdiction over gulf beaches must submit its beach management plan and amendments to the plan to the GLO for certification, including a plan to impose or increase public beach access, parking, or use fees. The Cameron County Commissioners Court amended the County's Plan by order adopted on August 26, 2010. The GLO is required to review such plans and certify by rule those plans that are consistent with the Open Beaches Act, the Dune Protection Act, and the Beach/Dune Rules. The certification by rule reflects the state's approval of the plan, but the text of the plan is not adopted by the GLO. 31 TAC §15.3(o)(4).

Cameron County is a coastal county consisting of areas bordering Willacy County to the north, Hidalgo County to the west, the Gulf of Mexico to the east and the Mexican State of Tamaulipas to the south. The areas governed by the Plan include those beaches and adjacent areas bordering the Gulf of Mexico located in unincorporated areas within the County.

THE 2010 CAMERON COUNTY PLAN AMENDMENTS

On August 26, 2010, the Cameron County Commissioners Court adopted amendments to the 1994 Plan and submitted those amendments to the GLO with a request for certification. Cameron County has requested an approval of an increase in the beach user fee imposed in accordance with 31 TAC §15.8 and Texas Natural Resources Code §61.022(c). Cameron County is seeking to amend its dune protection and beach access plan. As provided in 31 TAC §15.8, local governments may request an increase in beach user fees provided that the local government demonstrates that there are additional costs to the local government for providing public services and facilities directly related to the public beach. On August 26, 2010 the Cameron County Commissioners Court passed a Resolution, which amended its dune protection and beach access plan to increase the beach user fee imposed by County pursuant to 31 TAC §15.8 from $4 per day to $12 per day for passenger cars, $2 per day to $12 per day for motorcycles, $10/15 per day to $25 per day for passenger buses, $39 to $100 for annual park passes, and deletes the 90-day pass and bulk rate pass and implements a $25 30-day pass. Based on the information provided by Cameron County, the GLO has determined that the fee increase requested by this jurisdiction is reasonable in that it does not exceed the necessary and actual cost of providing reasonable beach-related facilities and services, does not unfairly limit public use of and access to and from public beaches in any manner, and is consistent with §15.8 of the Beach/Dune Rules and the Open Beaches Act. Therefore, the GLO finds that the approved amendments to the Plan are consistent with state law and hereby approves and certifies the County's 2010 Plan Amendment with no variances from the Beach/Dune Rules.

REASONED JUSTIFICATION

The justification for the adopted amendment certifying the County's 2010 Plan Amendment for an increase in the beach user fees imposed by the County is that the increased fees are necessary for Cameron County to continue to fund and provide adequate and improved beach-related services to the public including: funding for ensuring safe use of and access to and from the public beach, including vehicular controls, management, and parking regulations; acquisition and maintenance of off-beach parking areas and access ways; construction of accessible (ADA) dune walkovers; sanitation and litter control, including providing and servicing trash receptacles and conducting a trash abatement program; beach maintenance, including removal of debris and raking of seaweed; law enforcement; beach/dune system education; beach/dune protection and restoration projects; providing public facilities such as portable and fixed restroom facilities, showers, and picnic areas; and permitting of recreational and refreshment vendors.

SUMMARY AND RESPONSE TO COMMENTS

No public comments were received during the thirty (30) day comment period.

CONSISTENCY WITH CMP

The adoption of the amendment to §15.32 relating to Certification Status of Cameron County Dune Protection and Beach Access Plan is subject to the Coastal Management Program (CMP) as provided in Texas Natural Resources Code §33.2053(a)(10) and 31 TAC §505.11(a)(1)(J), relating to the Actions and Rules Subject to the CMP, and must be consistent with the applicable CMP goals and policies under §501.26, relating to Policies and Construction in the Beach/Dune System. The GLO has reviewed the adopted rule change for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Council (Council). The adopted rule change is consistent with the GLO Beach/Dune regulations that the Council has determined to be consistent with the CMP. Consequently, the Land Office has determined that the adopted rule change is consistent with the applicable CMP goals and policies.

ENVIRONMENTAL REGULATORY ANALYSIS

The GLO has evaluated the adopted rule change in light of the regulatory analysis requirements of Texas Government Code §2001.0225, and determined that the adopted rule change is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute. "Major environmental rule" means a rule, the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The adopted amendments are not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the adopted rule change implements legislative requirements in Texas Natural Resources Code §§61.011, 61.015(b), and 61.022(e), which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify that plans to impose or increase public beach access, parking, or use fees are consistent with state law.

STATUTORY AUTHORITY

The amendments are adopted under the Texas Natural Resources Code §§61.011, 61.015(b), and 61.022(b) and (c), and 61.070, which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify

that plans to impose or increase public beach access, parking, or use fees are consistent with state law.

Texas Natural Resources Code §§61.011, 61.015, 61.022, and 61.070 are affected by the proposed amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100151
Trace Finley
Deputy Commissioner, Policy and Governmental Affairs
General Land Office
Effective date: February 3, 2011
Proposal publication date: November 26, 2010
For further information, please call: (512) 475-1859

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# TITLE 43. TRANSPORTATION

## PART 10. TEXAS DEPARTMENT OF MOTOR VEHICLES

### CHAPTER 207. PUBLIC INFORMATION
### SUBCHAPTER A. ACCESS TO OFFICIAL RECORDS

**43 TAC §207.3**

The Texas Department of Motor Vehicles (department) adopts amendments to Chapter 207, Subchapter A, §207.3, concerning public access. The amendments to §207.3 are adopted with changes to the proposed text as published in the November 26, 2010, issue of the *Texas Register* (35 TexReg 10490).

EXPLANATION OF ADOPTED AMENDMENTS

The amendments to §207.3 are necessary to clarify the types of identification that are acceptable for accessing personal motor vehicle information.

The department's motor vehicle records contain personal information, as defined by Transportation Code, §730.003(6), including social security numbers, names, addresses, and medical or disability information. The Texas statutory definition is based on federal law. License plate numbers are also considered information subject to nondisclosure by the Texas Attorney General, Open Records Decision No. GA-684.

Section 207.3 provides that personal information may only be released if the requestor is the subject of the record, if the requestor has written authorization for release from the subject of the record, or if the intended use is for one of the lawful permitted uses. The amendments specify that a person requesting such information must present a current photo identification containing a unique identification number. The documents acceptable to the department will be a United States, or territory of the United States, driver's license or state identification certificate, a United States passport, or a foreign passport. Changes to the amendments originally proposed indicate that other identification documents acceptable to the department are unexpired Department of Homeland Security or United States Citizenship and Immigration Services identification, and unexpired United States Military identification cards.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §1002.001, which provides the Board of the Texas Department of Motor Vehicles with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

Government Code, Chapter 552; Transportation Code, §502.008 and Chapter 730; and 18 U.S.C. §2721 et seq.

*§207.3. Public Access.*

(a) Request for records.

(1) Submittal of request. A person seeking public information shall submit a request in writing to the department.

(A) A request made by other than electronic mail shall be submitted to:

*(i)* the department's General Counsel;

*(ii)* the department's Director of Public Information; or

*(iii)* the division director responsible for the information.

(B) A request made by electronic mail shall be sent via the department's World Wide Web site, located at http://www.dmv.state.tx.us/.

(2) Information required. A request for official records shall include the name, address, and telephone number of the requestor, and a description of the records in sufficient detail to permit efficient gathering of the requested items. The request shall also include the preferred mailing, facsimile transmission, or electronic mail address at which the requestor wishes to receive a cost itemized statement provided pursuant to Government Code, §552.2615(a) and §207.4(d) of this subchapter (relating to Cost of Copies of Official Records).

(3) Vehicle title and registration information.

(A) The department will provide certain vehicle registration information by telephone or upon receipt of a written request. Requested information will be released in accordance with 18 U.S.C. §2721 et seq., Transportation Code, §502.008, and Transportation Code, Chapter 730.

(B) The department will provide a written form for requests for motor vehicle registration information. A completed and properly executed form must include, at a minimum:

*(i)* the name and address of the requestor;

*(ii)* the Texas license number, title or document number, or vehicle identification number of the motor vehicle about which information is requested;

*(iii)* a statement that the requested information may only be released if the requestor is the subject of the record, if the requestor has written authorization for release from the subject of the record, or if the intended use is for one of the permitted uses indicated on the form;

*(iv)* a statement that the information is requested for a lawful and legitimate purpose in accordance with Transportation Code, §502.008;

*(v)* a certification that the statements made on the form are true and correct; and

*(vi)* the signature of the requestor.

(C) The department will provide vehicle registration information by license number by telephone only in accordance with 18 U.S.C. §2721 et seq., Transportation Code, §502.008, and Transportation Code, Chapter 730, and only if requested by:

*(i)* a peace officer acting in an official capacity; or

*(ii)* an official of the state, city, town, county, special district, or other political subdivision, utilizing the obtained information for tax purposes or for the purpose of determining eligibility for a state public assistance program.

(D) A person may not receive information under this paragraph unless the person presents current photo identification containing a unique identification number and the document is a:

*(i)* driver's license or state identification certificate issued by a state or territory of the United States;

*(ii)* United States or foreign passport;

*(iii)* unexpired United States military identification card; or

*(iv)* unexpired United States Department of Homeland Security or United States Citizenship and Immigration Services identification document.

(b) Production of records. Except as provided in subsections (a), (d), (e), and (f) of this section, the department will provide copies, or promptly produce, official department records for inspection, duplication, or both. If the requested information is unavailable for inspection at the time of the request because it is in active use or otherwise not readily available, the department will certify this fact, in writing, within 10 business days after the date the information is requested to the applicant and specify a date, within a reasonable time when the record will be available for inspection or duplication.

(c) Examination of information.

(1) A person requesting to examine official records in the offices of the department must complete the examination without disrupting the normal operations of the department and not later than the 10th day after the date the records are made available to the person. Upon written request, the department will extend the examination period by increments of 10 days, not to exceed a total of 30 days.

(2) The inspection of records may be interrupted by the department if the records are needed for use by the department. The period of interruption will not be charged against the requestor's 10-day period to examine the records.

(3) A person may not remove an original copy of an official department record from the offices of the department.

(d) Request for opinion. If the department considers that requested records fall within an exception under the Government Code, and that the records should be withheld, the department will ask for a decision from the attorney general about whether the records are within that exception if there has not been a previous determination about whether the records fall within one of the exceptions. The request for a decision from the attorney general will be made by the 10th business day after the date of receiving the written request.

(e) Confidential information and privacy protection.

(1) The department will not provide records considered to be confidential by law or otherwise prohibited from release under the Government Code or other provisions of law.

(2) A legislative member, agency, or committee may request confidential information if the public information requested is for legislative purposes. The department may require the requesting legislative agency or committee, or the member or employee of the requesting entity, to sign a confidentiality agreement that requires the following provisions.

(A) The information shall not be disclosed outside the requesting entity, or within the requesting entity for purposes other than the purpose for which it was received.

(B) The information shall be labeled confidential.

(C) The information shall be kept securely.

(D) The number of copies of the information or the notes taken from the information that are not destroyed or returned to the department remain confidential and subject to the confidentiality agreement.

(f) Repetitious or redundant requests. The department may elect not to provide records if the department has previously furnished the same copies or made the same information available to the requestor. In the event that the department elects not to provide records under this subsection, the department will provide the requestor with a certification that includes:

(1) a description of the information previously made available to the requestor;

(2) the date that the department received the requestor's previous request for the information;

(3) the date that the department previously made the information available to the requestor;

(4) a statement that no subsequent additions, deletions, or corrections have been made to that information; and

(5) the name, title, and signature of the department official responsible for the information.

(g) Certified records. The following officials shall serve as the executive director's authorized representatives for the purpose of certifying official department records.

(1) The department's executive director may certify board orders. The executive director may delegate certification authority to other officials to assure sufficient availability of authorized certifying officials.

(2) Other official records of the department may be certified by the division director or other department official having official custody of the records. A division director may delegate certification authority to other officials to assure sufficient availability of authorized certifying officials.

(h) Programming and manipulation of data.

(1) If responding to a request for information will require programming or manipulation of data, and compliance with the request, is not feasible or will result in substantial interference with the department's ongoing operations, or, if the information could be made available in the requested form only at a cost that covers the programming and manipulation of data, the department will provide a written statement within 20 days after the date of the receipt of the request. The statement will include:

(A) a statement that the information is not available in the requested form;

(B) a description of the form in which the information is available;

(C) a description of any contract or services that would be required to provide the information in the requested form;

(D) a statement of the estimated cost of providing the information; and

(E) a statement of the anticipated time required to provide the information.

(2) If the department gives written notice within 20 days after the date of receipt of the request to the person making the request that additional time is needed, the department may have an additional 10 days to issue the statement in paragraph (1) of this subsection.

(3) The department will not provide the information until the person making the request states in writing that the requestor wants:

(A) the department to provide the information according to the cost and time parameters set out in the statement; or

(B) the information in the form in which it is available.

(i) Correction of non-license information. This subsection does not apply to license amendment procedures. An individual may request the correction of information about that individual in the following manner:

(1) A request to correct information may be submitted in writing or through the department's World Wide Web site, located at http://www.dmv.state.tx.us/. The request must be directed to division director responsible for the information.

(2) The request must include the individual's name, address, and telephone number.

(3) The request must identify the record to be corrected with as much specificity as reasonably possible. The department will not process requests that do not identify particular records.

(4) This subsection applies only to a request to correct information that relates directly to an individual, including the individual's name, address, telephone number, and similar information.

(5) The department may contact the individual or take other steps as necessary to verify the individual's identity. The department may also contact the individual or take other steps as necessary to obtain additional information with regard to the record to be corrected, the nature of the correction to be made, the reasons that the current information maintained by the department is incorrect, or other relevant matters.

(6) The division director responsible for the information will determine if the current information, maintained by the department, is incorrect.

(A) If the current information, maintained by the department, is determined to be incorrect, the department's records will be corrected. The division director responsible for the information will determine the manner in which the correction will be made.

(B) If the current information, maintained by the department, is determined to be correct, the request for correction will be noted in connection with the relevant record.

(C) The department may refuse to alter records that were correct at the time they were first prepared, but are no longer correct. If the department refuses to alter a record that was correct at the time it was first prepared, but is no longer correct, the request for correction will be noted in connection with the relevant record.

(7) This subsection does not authorize the cancellation, issuance, or alteration of any official record, including a title, a license, or a permit. Application for a new official record must be made in the manner required by law.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100138
Brett Bray
General Counsel
Texas Department of Motor Vehicles
Effective date: February 3, 2011
Proposal publication date: November 26, 2010
For further information, please call: (512) 463-8683

# CHAPTER 215. MOTOR VEHICLE DISTRIBUTION

## SUBCHAPTER D. FRANCHISED DEALERS, MANUFACTURERS, DISTRIBUTORS, AND CONVERTERS

### 43 TAC §215.109

The Texas Department of Motor Vehicles (department) adopts amendments to §215.109, concerning replacement dealerships. The amendments to §215.109 are adopted without changes to the proposed text as published in the October 29, 2010, issue of the *Texas Register* (35 TexReg 9673) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The amendments to §215.109 expand the distance that a replacement dealership may be placed from the location of a closed dealership without being subject to protest by surrounding eligible same line-make dealers and to clarify notice requirements. During the 2009, 81st Legislature, Regular Session, House Bill 2640 made changes to the Occupations Code allowing dealers to file applications to relocate their dealerships up to two miles from an existing location without being subject to protest. These amendments to §215.109 governing replacement dealers will bring this section into conformity with the changes previously made to protest parameters for relocated dealers. The Board expects that this will benefit regulated entities by increasing clarity and reducing confusion over the application of the protest rules in the two circumstances.

The amendments to §215.109(4) will change the language of this section to allow a replacement dealership up to two miles from the location of a closed dealership without risk of protest, instead of only one mile from that dealership as the current language allows. Thus, the distance exempt from protest under §215.109 will be consistent with the distance exempt from protest under Occupations Code, §2301.652(c)(1) and 43 TAC §215.105. This consistency will promote clarity amongst manufacturers and distributors and dealers that wish to file applications or protests under either rule.

Also, the language of §215.109(2) is amended to clarify the notice requirements that manufacturers or distributors must meet in order to designate a replacement dealer in the market. The language specifies that the manufacturer or distributor must notice all like-line dealerships within the county or a 15-mile radius from where the replaced dealership was located.

To ensure that the dealer and manufacturer/distributor communities are clear regarding the intended application of the rule, the Board announces that the language regarding the change from one mile to two miles, if adopted, will apply to dealership closures that occur on or after February 1, 2011. The designated replacement dealership for a dealership closed prior to February 1, 2011 can only be within one mile of the closed location to be designated exempt from protest.

Additional changes to this section are grammar and punctuation changes intended to improve the clarity of the section.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §1002.001, which provides the Board of the Texas Department of Motor Vehicles with the authority to establish rules for the conduct of the work of the department, and more specifically, Occupations Code, §2301.153 which provides the Board with the authority to adopt rules relating to Motor Vehicle Distribution.

CROSS REFERENCE TO STATUTE

Occupations Code, §2301.453 and §2301.652.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2011.

TRD-201100139
Brett Bray
General Counsel
Texas Department of Motor Vehicles
Effective date: February 10, 2011
Proposal publication date: October 29, 2010
For further information, please call: (512) 463-8683

# REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

## Adopted Rule Reviews

### Railroad Commission of Texas

**Title 16, Part 1**

The Railroad Commission of Texas files this notice of completion of the review and re-adoption of 16 TAC Chapter 4, relating to Environmental Protection, in accordance with Texas Government Code, §2001.039. The notice of review was published in the November 19, 2010, issue of the *Texas Register* (35 TexReg 10287). The agency's reasons for adopting these rules continue to exist. In a separate, concurrent rulemaking, the Commission adopts some non-substantive amendments to various rules in Chapter 4.

The Commission received no comments on the proposed rule review or amendments.

TRD-201100176
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Filed: January 18, 2011

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### Texas Veterans Land Board

**Title 40, Part 5**

In accordance with the notice of proposed rule review published in the August 13, 2010, issue of the *Texas Register* (35 TexReg 7087) the Texas Veteran's Land Board (VLB) has reviewed and considered for readoption, revision or repeal Chapters 175, 176, 177, and 178 concerning "The General Rules of the Veterans Land Board, Veterans Homes, Veterans Housing Assistance Program and Texas State Veterans Cemeteries." The rule review was conducted under the VLB's rule review plan published in the April 23, 2010, issue of the *Texas Register* (35 TexReg 3297), as required by Texas Government Code §2001.039.

No public comments were received on the proposed rule review.

The VLB considered, among other things, whether the reasons for adoption of these rules continue to exist. As a result of the review, the VLB determined that the rules in Chapters 175, 176, 177, and 178 concerning "The General Rules of the Veterans Land Board, Veterans Homes, Veterans Housing Assistance Program and Texas State Veterans Cemeteries" are still necessary, with revisions necessary to reflect recent legislative changes and agency practices. A Notice of Proposed Rulemaking to adopt amendments to Chapters 175, 176, 177, and 178 concerning "The General Rules of the Veterans Land Board, Veterans Homes, Veterans Housing Assistance Program and Texas State Veterans Cemeteries" was published in the August 20, 2010, issue of the *Texas Register* (35 TexReg 7189). A notice of adoption of these amendments was published in the December 17, 2010, issue of the *Texas Register* (35 TexReg 11390).

This completes the VLB's review of Chapters 175, 176, 177, and 178 concerning "The General Rules of the Veterans Land Board, Veterans Homes, Veterans Housing Assistance Program and Texas State Veterans Cemeteries."

TRD-201100172
Larry L. Laine
Deputy Commissioner, Policy and Governmental Affairs, General Land Office
Texas Veterans Land Board
Filed: January 18, 2011

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# TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

# Figure: 19 TAC §109.1002(f)

**School FIRST - Rating Worksheet Dated December 2010**
**School Year ____-____**
**Fiscal Year Ended June 30, ____ Or August 31, ____**
**County District # _____-_____**
**District Name :_____**

| | Critical Indicators | Check The Appropriate Box Below: Yes | No |
|---|---|---|---|
| 1 | Was Total Fund Balance Less Reserved Fund Balance Greater Than Zero In The General Fund? | | |
| 2 | Was The Total Unrestricted Net Asset Balance (Net Of Accretion OF Interest On Capital Appreciation Bonds) In The Governmental Activities Column In The Statement Of Net Assets Greater Than Zero? (If The District's Five-Year Percent Change In Students Was A 10% Increase Or More Then Answer Yes) | | |
| 3 | Were There No Disclosures In The Annual Financial Report And/Or Other Sources Of Information Concerning Default On Bonded Indebtedness Obligations? | | |
| 4 | Was The Annual Financial Report Filed Within One Month After November 27th or January 28th Deadline Depending Upon The District's Fiscal Year End Date (June 30th or August 31st)? | | |
| 5 | Was There An Unqualified Opinion In Annual Financial Report? | | |
| 6 | Did The Annual Financial Report Not Disclose Any Instance(s) Of Material Weaknesses In Internal Controls? | | |

| | Fiscal Responsibility And Data Quality | Points |
|---|---|---|
| 7 | Was The Three-Year Average Percent Of Total Tax Collections (Including Delinquent) Greater Than 98%? | |
| 8 | Did The Comparison Of PEIMS Data To Like Information In Annual Financial Report Result In An Aggregate Variance Of Less Than 3 Percent Of Expenditures Per Fund Type (Data Quality Measure)? | |
| 9 | Were Debt Related Expenditures (Net Of IFA And/Or EDA Allotment) Less Than $350 Per Student? (If The District's Five-Year Percent Change In Students Was A 7% Increase Or More, Or If Property Taxes Collected Per Penny Of Tax Effort Were More Than $200,000, Then The District Receives 5 Points) | |
| 10 | Was There No Disclosure In The Annual Audit Report Of Material Noncompliance? | |
| 11 | Did The District Have Full Accreditation Status In Relation To Financial Management Practices? (e.g., No Monitor, Conservator, Management Team, or Board of Managers Assigned) | |
| | **Budgeting** | |
| 12 | Was The Aggregate Of Budgeted Expenditures And Other Uses Less Than The Aggregate Of Total Revenues, Other Resources and Fund Balance in General Fund? | |
| 13 | If The District's Aggregate Fund Balance In The General Fund And Capital Projects Fund Was Less Than Zero, Were Construction Projects Adequately Financed? (Were Construction Projects Adequately Financed Or Adjusted By Change Orders Or Other Legal Means To Avoid Creating Or Adding To The Fund Balance Deficit Situation?) | |
| 14 | Was The Ratio Of Cash And Investments To Deferred Revenues (Excluding Amount Equal To Net Delinquent Taxes Receivable) In The General Fund Greater Than Or Equal To 1:1? (If Deferred Revenues Are Less Than Net Delinquent Taxes Receivable, Then The District Receives 5 Points) | |
| | **Personnel** | |
| 15 | Was The Administrative Cost Ratio Less Than The Threshold Ratio? (See Ranges Below) | |
| 16 | Was The Ratio Of Students To Teachers Within The Ranges Shown Below According To District Size? | |
| 17 | Was The Ratio Of Students To Total Staff Within The Ranges Shown Below According To District Size? | |
| | **Cash Management** | |
| 18 | Was The Total Fund Balance In The General Fund More Than 50% And Less Than 150% of Optimum According To The Fund Balance and Cash Flow Calculation Worksheet in the Annual Financial Report? | |
| 19 | Was The Decrease In Undesignated Unreserved Fund Balance Less Than 20% Over Two Fiscal Years? (If 1.5 Times Optimum Fund Balance Is Less Than Total Fund Balance In General Fund Or If Total Revenues Exceeded Operating Expenditures In The General Fund, Then The District Receives 5 Points). | |
| 20 | Was The Aggregate Total Of Cash And Investments In The General Fund More Than $0? | |
| 21 | Were Investment Earnings In All Funds (Excluding Debt Service Fund and Capital Projects Fund) More Than $15 Per Student? | |
| | **Total Points Per Column** | |

| Determination of Points | | | | | |
|---|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 | 0 |
| > 98% | > 95% =< 98% | > 92% =< 95% | > 89% =< 92% | > 86% =< 89% | =< 86% |
| Yes | | | | | No |
| < $350 | => $350 < $600 | => $600 < $850 | => $850 < $1,100 | => $1,100 < $1,350 | => $1,350 |
| Yes | | | | | No |
| Yes | | | | | No |
| Yes | | | | | No |
| Yes | | | | | No |
| => 1.00 | => 0.95 < 1.00 | => 0.90 < 0.95 | => 0.85 < 0.90 | => 0.80 < 0.85 | < 0.80 |
| Yes | | | | | No |
| <= 100% | > 100% =< 105% | > 105% =< 110% | > 110% =< 115% | > 115% =< 120% | > 120% |
| => 100% | => 95% < 100% | => 90% < 95% | => 85% < 90% | => 80% < 85% | < 80% |
| <= 100% | > 100% =< 105% | > 105% =< 110% | > 110% =< 115% | > 115% =< 120% | > 120% |
| => 100% | => 95% < 100% | => 90% < 95% | => 85% < 90% | => 80% < 85% | < 80% |
| **UL < 150% | > 150% =< 152.5% | > 152.5% =< 155.0% | > 155.0% =< 157.5% | > 157.5% =< 160.0% | > 160.0% |
| ***LL > 50% | > 47.5% =< 50% | > 45.0% =< 47.5% | > 42.5% =< 45.0% | > 40.0% =< 42.5% | =< 40.0% |
| < 20% | => 20% < 21% | => 21% < 22% | => 22% < 23% | => 23% < 24% | => 24% |
| Yes | | | | | No |
| > $15 | > $14 =< $15 | > $13 =< $14 | > $12 =< $13 | > $11 =< $12 | =< $11 |

Determination Of School District Rating

| | | | |
|---|---|---|---|
| A. | | Did The District Answer No To Indicators 1, 2, 3, Or 4; OR Both 5 and 6<br>If The District Answered No To Either, The District's Rating Is SubStandard Achievement | |
| B. | | Determine Rating By Applicable Number Of Points | Points |
| | | **Superior Achievement** | >= 67 <= 75 |
| | | **Above Standard Achievement** | >= 59 < 67 |
| | | **Standard Achievement** | >= 51 < 59 |
| | | **Substandard Achievement** *(If Less Than 51 points, OR If The District Answered No To Indicators 1, 2, 3, Or 4, OR Both 5 And 6* | <51 OR Answered No To One Default Indicator |

| Administrative Cost Ratio Indicator 15 | |
|---|---|
| ADA Group | Standard |
| 10,000 and Above | 0.1105 |
| 5,000 to 9,999 | 0.1250 |
| 1,000 to 4,999 | 0.1401 |
| 500 to 999 | 0.1561 |
| Less than 500 | 0.2654 |
| Sparse | 0.3614 |

** UL = Upper Limit
*** LL = Lower Limit

For Questions Call The Division Of School Financial Audits At (512) 463-9095

Completed By:_____ Date:_____

Notes:

| Disrtrict Size - Number Of Students Between | | | Ranges For Ratios | |
|---|---|---|---|---|
| | | | Low | High |
| Indicator 16 | | | | |
| | | < 500 | 7.0 | 22 |
| | 500 | 999 | 10.0 | 22 |
| | 1,000 | 4,999 | 11.5 | 22 |
| | 5,000 | 9,999 | 13.0 | 22 |
| | => 10,000 | | 13.5 | 22 |
| Indicator 17 | | | | |
| | | < 500 | 5.0 | 14 |
| | 500 | 999 | 5.8 | 14 |
| | 1,000 | 4,999 | 6.3 | 14 |
| | 5,000 | 9,999 | 6.8 | 14 |
| | => 10,000 | | 7.0 | 14 |

| School FIRST - Rating Worksheet Calculations Dated December 2010 | | |
|---|---|---|
| | **Indicator** | **Calculation Defined** |
| 1 | Was Total Fund Balance Less Reserved Fund Balance Greater Than Zero In The General Fund? | A > 0 Where A = [Aggregate Of Unreserved, Designated Fund Balance And Unreserved, Undesignated Fund Balance In General Fund At June 30 or August 31 Depending On Fiscal Year End] |
| 2 | Was the Total Unrestricted Net Asset Balance (Net of the Accretion of Interest for Capital Appreciation Bonds) in the Governmental Activities Column in the Statement of Net Assets Greater Than Zero? (If The District's Five-Year Percent Change In Students Was A 10% Increase Or More Then The District Answers Yes) | If ((C – D)/ D) X 100 < 10 % Then Continue Calculation A + B> 0 Where A = [Total Unreserved Net Asset Balance in the Governmental Activities Column in Exhibit A-1, Statement of Net Assets in the Annual Financial Report]; B= [Accretion of Interest for Capital Appreciation Bonds]; C = [Number Of Students In Year 5 From Base Year]; D = [Number Of Students In Base Year] |
| 3 | Were There **No** Disclosures In The Annual Financial Report And/Or Other Sources Of Information Concerning Default On Bonded Indebtedness Obligations? | No Calculation Involved |
| 4 | Was The Annual Financial Report Filed Within One Month After November 27th or January 28th Deadline Depending Upon The District's Fiscal Year End Date (June 30th or August 31st)? | No Calculation Involved |
| 5 | Was There An Unqualified Opinion In Annual Financial Report? | No Calculation Involved |
| 6 | Did The Annual Financial Report **Not** Disclose Any Instance(s) Of Material Weaknesses In Internal Controls? | No Calculation Involved |
| 7 | Was The Three-Year Average Percent Of Total Tax Collections (Including Delinquent) Greater Than 98%? | ((A / B) X 100) Where A = [Tax Collections For Three Years ]; B = [Tax Levy For Three Years] Reported In Exhibit J-1 Schedule of Delinquent Taxes Receivable In The Annual Financial Report |
| 8 | Did The Comparison Of PEIMS Data To Like Information In Annual Financial Report Result In An Aggregate Variance Of Less Than 3 Percent Of Expenditures Per Fund Type (Data Quality Measure)? | ((A / B) X 100) Of C Where A = [Absolute Value Of All Differences In Expenditures In Exhibit C-2 Statement of Revenues, Expenditures, and Changes in Fund Balance And PEIMS]; B = [Sum Of Expenditure In PEIMS Per Fund Type Presented In Exhibit C-2]; C = [Fund Class] |

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| School FIRST - Rating Worksheet Calculations Dated December 2010 | | |
|---|---|---|
| | **Indicator** | **Calculation Defined** |
| 9 | Were Debt Related Expenditures (Net Of IFA And/Or EDA Allotment) Less Than $350 Per Student? (If The District's Five-Year Percent Change In Students Was A 7% Increase Or More, Or If Property Taxes Collected Per Penny Of Tax Effort Were More Than $200,000, Then The District Receives 5 Points) | If ((B – D)/ D) X 100 < 7 % Or E / F < $200,000, Then Continue Calculation ((A - C )/ B) Where A = [Function 71 Expenditures Report In The Debt Service And General Funds (Excluding Expenditure Object Codes 6524 and 6525)]; B = [Number Of Students In Year 5 From Base Year]; C = [IFA + EDA Allotments]; D = [Number Of Students In Base Year]; E = [Total Tax Collections]; F = [Total Tax Rate In Pennies] |
| 10 | Was There **No** Disclosure In The Annual Audit Report Of Material Noncompliance? | No Calculation Involved |
| 11 | Did The District Have Full Accreditation Status In Relation To Financial Management Practices? (e.g., Monitor, Conservator, Management Team, or Board of Managers Assigned) | No Calculation Involved |
| 12 | Was The Aggregate Of Budgeted Expenditures And Other Uses **Less Than** The Aggregate Of Total Revenues, Other Resources and Fund Balance in General Fund? | (A + B) - (C + D + E) < 0 Where A = [Budgeted Appropriations In General Fund]; B = [Budgeted Other Uses In The General Fund]; C = [Budgeted Revenues In General Fund]; D = [Budgeted Other Resources In The General Fund]; E = [Fund Balance In General Fund At July 1 or September 1 Depending On Fiscal Year End] |
| 13 | If The District's Aggregate Fund Balance In The General Fund And Capital Projects Fund Was **Less Than** Zero, Were Construction Projects Adequately Financed? (Were Construction Projects Adequately Financed Or Adjusted By Change Orders Or Other Legal Means To Avoid Creating Or Adding To The Fund Balance Deficit Situation?) | If (C + D) < 0 Then Continue Calculation As (A - B - (C + D)) < 0 Where A = [Expenditures Function 81 In General Fund and Capital Projects Fund]; B = [Other Resources For Real Property Financing In General Fund and Capital Projects Fund]; C = [Fund Balance In General Fund At July 1 or September 1 Depending On Fiscal Year End]; D = [Fund Balance In Capital Projects Fund At July 1 or September 1 Depending On Fiscal Year End] |
| 14 | Was The Ratio Of Cash And Investments To Deferred Revenues (Excluding Amount Equal To Net Delinquent Taxes Receivable) In The General Fund Greater Than Or Equal To 1:1? (If Deferred Revenues Are Less Than Net Delinquent Taxes Receivable, Then The District Receives 5 Points) | If B > 0 Then Continue Calculation As (A / B) Where A = [Cash And Investments In General Fund]; B = [Deferred Revenue In General Fund – Property Tax Receivable Net Of Uncollectible] |

December 2010

| School FIRST - Rating Worksheet Calculations Dated December 2010 | | |
|---|---|---|
| | **Indicator** | **Calculation Defined** |
| 15 | Was The Administrative Cost Ratio Less Than The Threshold Ratio? (See Ranges Below) | (A>B) A = [Acceptable Administrative Cost Ratio]; B = [Administrative Cost Ratio Of The District] |
| 16 | Was The Ratio Of Students To Teachers Within The Ranges Shown Below According To District Size? (See Ranges Below) | (A / B) Where A = [Number Of Students]; B = [Number Of Teachers FTEs] |
| 17 | Was The Ratio Of Students To Total Staff Within The Ranges Shown Below According To District Size? (See Ranges Below) | (A / B) Where A = [Number Of Students]; B = [Total Staff FTEs] |
| 18 | Was The Total Fund Balance In The General Fund More Than 50% And Less Than 150% of Optimum According To The Fund Balance and Cash Flow Calculation Worksheet in the Annual Financial Report? | Deficient Fund Balance Amount In General Fund Is Defined As A < ((B X .5) And Excess Is Defined As A > (B X 1.5) Where A = [Total General Fund Balance At June 30, 20XX or August 31, 20XX Depending On Fiscal Year End]; B = Line 10 in Exhibit J-3, Fund Balance and Cash Flow Calculation Worksheet in the Annual Financial Report. |
| 19 | Was The Decrease In Undesignated Unreserved Fund Balance Less Than 20% Over Two Fiscal Years? (If 1.5 Times Optimum Fund Balance Is Less Than Total Fund Balance In General Fund Or If Total Revenues Exceeded Operating Expenditures In The General Fund, Then The District Receives 5 Points). | If (A – B) > 0 And Optimum Fund Balance X 1.5 Is Less Than Total Fund Balance In General Fund And [C] X .80 > [D], Then Continue Calculation [A] - [B] Where A = [Expenditures In General Fund In Functions 11 Through 61 And Expenditure Object Codes 6100 Through 6400]; B = [Total Revenues In General Fund]; C = [Undesignated, Unreserved Fund Balance In General Fund At June 30 or August 31, Depending On Fiscal Year End, Two Fiscal Years Prior]; D= [Undesignated, Unreserved Fund Balance In General Fund For The Last Fiscal Year] |
| 20 | Was The Aggregate Total Of Cash And Investments In The General Fund More Than $0? | A > 0 Where A = [Cash and Investments In General Fund] |
| 21 | Were Investment Earnings In All Funds (Excluding Debt Service Fund And Capital Projects Fund) More Than $15 Per Student? | (A / B) Where A = [Investment Earnings In All Funds Except Debt Service Fund And Capital Projects Fund]; B = [Number Of Students] |

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| Indicator 15 | |
|---|---|
| ADA Group | Standard |
| 10,000 and Above | 0.1105 |
| 5,000 to 9,999 | .1250 |
| 1,000 to 4,999 | .1401 |
| 500 to 999 | .1561 |
| Less than 500 | .2654 |
| Sparse | 0.3614 |

| | | Ranges for Ratios | |
|---|---|---|---|
| District Size - Number of Students Between | | Low | High |
| Indicator 16 | | | |
| | <500 | 7.0 | 22 |
| 500 | 999 | 10.0 | 22 |
| 1,000 | 4,999 | 11.5 | 22 |
| 5,000 | 9,999 | 13.0 | 22 |
| =>10,000 | | 13.5 | 22 |
| Indicator 17 | | | |
| | <500 | 5.0 | 14 |
| 500 | 999 | 5.8 | 14 |
| 1,000 | 4,999 | 6.3 | 14 |
| 5,000 | 9,999 | 6.8 | 14 |
| =>10,000 | | 7.0 | 14 |

For Questions Call The Division Of School Financial Audits At (512) 463-9095

December 2010

Figure: 19 TAC §109.1002(g)

**School FIRST for Charter Schools - Rating Worksheet Dated December 2010**
**School Year _____ - _____**
**Fiscal Year Ended June 30, _____ or August 31, _____**
**County District # _____ - _____**
**Charter School Name _____**

| | | Critical Indicators | Check The Appropriate Box Below: Yes | No |
|---|---|---|---|---|
| 1 | | Did The Charter School (CS) Avoid Holds On Payments That Were Not Cleared Within 30 Days, As A Result Of Untimely Deposits To TRS Or TWC? | | |
| 2 | | Was The Total Net Asset Balance In The Statement Of Financial Position For The CS Greater Than Zero? (If The CS's Five-Year Percent Change In Students Was A 10% Increase Or More Then Answer Yes) | | |
| 3 | * | Were There No Disclosures In The Charter Holder's (CH's) Annual Financial Report And/Or Other Sources Of Information Concerning Default On Debt? | | |
| 4 | * | Was The CH's Annual Financial Report Filed Within One Month After The November 27th Or January 28th Deadline Depending Upon The CS's Fiscal Year End Date (June 30th Or August 31st)? | | |
| 5 | * | Was There An Unqualified Opinion In The CH's Annual Financial Report? | | |
| 6 | * | Did The CH's Annual Financial Report Not Disclose Any Instance(s) Of Material Weaknesses In Internal Controls? | | |

| | | Fiscal Responsibility And Data Quality | Points | Determination Of Points: 5 | 4 | 3 | 2 | 1 | 0 |
|---|---|---|---|---|---|---|---|---|---|
| 7 | | Are the CS's Liabilities Less Than 80% of Its Assets? | | Yes | | | | | No |
| 8 | | Did The Comparison Of PEIMS Data To Like Information In The CS's Annual Financial Report Result In An Aggregate Variance Of Less Than 3 Percent Of All Expenses (Data Quality Measure)? | | Yes | | | | | No |
| 9 | | Were The CS's Debt Related Expenses Less Than $200 Per Student? (If The CS's Five-Year Percent Change In Students Was A 7% Increase Or More, Then The CS Receives 5 Points) | | < $200 | >= $200 < $350 | >= $350 <$500 | >= $500 < $650 | >= $650 < $800 | >= $800 |
| 10 | * | Was There No Disclosure In The CH's Annual Audit Report Of Material Noncompliance? | | Yes | | | | | No |
| 11 | | Did The CS Have Full Accreditation Status In Relation To Financial Management Practices? (e.g. No Monitor, Conservator, Management Team, Or Board of Managers Assigned) | | Yes | | | | | No |
| | | **Budgeting** | | | | | | | |
| 12 | | Was The CS's Aggregate Of Budgeted Expenses Less Than The Aggregate Of Budgeted Total Revenues And Cash And Investments At Beginning Of Year? | | Yes | | | | | No |
| 13 | | Was The CS's Current Ratio For All Net Asset Groups Greater Than Or Equal To 1:1? | | => 1.00 | =>0.95 < 1.00 | =>0.90 < 0.95 | =>0.85 < 0.90 | =>0.80 < 0.85 | < 0.80 |
| | | **Personnel** | | | | | | | |
| 14 | | Was The CS's Administrative Cost Ratio Less Than The Threshold Ratio? (See Ranges Below) | | Yes | | | | | No |
| 15 | | Was The Ratio Of Students To Teachers Within The Ranges Shown Below According To CS Size? (See Ranges Below) | | **UL<= 100%<br>***LL => 100% | >100% =<105%<br>=>95% <100% | >105% =<110%<br>=>90% <95% | >110% =<115%<br>=>85% <90% | >115% =<120%<br>=>80% <85% | > 120%<br>< 80% |
| 16 | | Was The Ratio Of Students To Total Staff Within The Ranges Shown Below According To The CS's Size? (See Ranges Below) | | **UL <= 100%<br>***LL => 100% | >100% =<105%<br>=>95% <100% | >105% =<110%<br>=>90% <95% | >110% =<115%<br>=>85% <90% | >115% =<120%<br>=>80% <85% | > 120%<br>< 80% |
| | | **Cash Management** | | | | | | | |
| 17 | | Would The CS's Existing Assets Cover Two Months Of Operating Expenses? (Liquid Funds Indicator) | | Yes | | | | | No |
| 18 | | Was The Decrease In The CS's Total Net Assets Less Than 20% Over Two Fiscal Years? (Calculation Excludes Depreciation And Amortization) | | < 20.00% | =>20.0% < 21.0% | =>21.0% < 22.0% | =>22.0% < 23.0% | =>23.0% < 24.0% | => 24.0% |
| 19 | | Was The CS's Aggregate Total Of Cash And Investments More Than $0? | | Yes | | | | | No |
| 20 | | Were The CS's Investment Earnings In All Net Asset Groups More Than $5 Per Student? | | > $5 | >$4 =< $5 | >$3 =< $4 | >$2 =< $3 | >$1 =< $2 | =< $1 |
| 21 | | Could The CS Operate For Two Months Without Additional Funds? (Defensive Interval) | | >= 2.00 | >= 1.50 < 2.00 | >= 1.00 < 1.50 | >= 0.50 < 1.00 | >= 0.00 < 0.50 | < 0.00 |

Determination Of Charter School Rating

| | | |
|---|---|---|
| A. | Did The Charter School Answer No To Indicators 1, 2, 3, Or 4? OR Both 5 and 6? If The Charter School Answered No To Either, The Charter School's Rating Is Substandard Achievement | |
| B. | Determine Rating By Applicable Number Of Points | Points |
| | Superior Achievement | >= 64 <= 75 |
| | Above Standard Achievement | >= 54 < 64 |
| | Standard Achievement | >= 43 < 54 |
| | Substandard Achievement (If Less Than 43 points, OR If The Charter School **Answered No To Indicators 1, 2, 3, Or 4, OR Both 5 And 6)** | <43 or Answered No To One Default Indicator |

| Administrative Cost Ratio Indicator 14 | |
|---|---|
| ADA Group | Standard |
| 10,000 and Above | 0.1105 |
| 5,000 to 9,999 | 0.1250 |
| 1,000 to 4,999 | 0.1401 |
| 500 to 999 | 0.1561 |
| Less than 500 | 0.2654 |
| Sparse | 0.3614 |

** UL = Upper Limit
*** LL = Lower Limit

* In accordance with generally accepted accounting principles established by the Financial Accounting Standards Board (FASB), the financial statements for a non-profit entity must be presented with an aggregate view of the entity as a whole. The indicators with an asterisk are based on the results of the audited financial statements for the entity as a whole. All other indicators are calculated for the financial results presented for the specific-purpose financial statements relating to the operations of the individual charter school.

For Questions Call The Division Of School Financial Audits At (512) 463-9095

Completed By:_____ Date:_____

Notes:

| Charter School Size - Number Of Students Between | | | Ranges For Ratios | |
|---|---|---|---|---|
| | | | Low | High |
| Indicator 15 | | | | |
| | | < 500 | 7.0 | 22 |
| | 500 | 999 | 10.0 | 22 |
| | 1,000 | 4,999 | 11.5 | 22 |
| | 5,000 | 9,999 | 13.0 | 22 |
| | => 10,000 | | 13.5 | 22 |
| Indicator 16 | | | | |
| | | < 500 | 5.0 | 14 |
| | 500 | 999 | 5.8 | 14 |
| | 1,000 | 4,999 | 6.3 | 14 |
| | 5,000 | 9,999 | 6.8 | 14 |
| | => 10,000 | | 7.0 | 14 |

| School FIRST for Charter Schools - Rating Worksheet Calculations Dated December 2010 | | | |
|---|---|---|---|
| | | Indicator | Calculation Defined |
| 1 | | Did The Charter School (CS) Avoid Holds on Payments That Were Not Cleared Within 30 Days, as a Result of Untimely Deposits to TRS or TWC? | No Calculation Involved; Source: e-mails from TEA Accounting regarding FSP holds (if not cleared in < 30 days) |
| 2 | | Was The Total Net Asset Balance In The Statement Of Financial Position for the CS Greater Than Zero? (If The CS's Five-Year Percent Change In Students Was A 10% Increase Or More Then Answer Yes) | If ((B – C)/ C) X 100 < 10 % Then Continue Calculation A > 0 Where A = Total Net Asset Balance in the Statement of Financial Position in the Annual Financial Report; B = [Number Of Students In Year 5 From Base Year]; C = [Number Of Students In Base Year] |
| 3 | * | Were There No Disclosures In The Charter Holder's (CH's) Annual Financial Report And/Or Other Sources Of Information Concerning Default On Debt? | No Calculation Involved |
| 4 | * | Was The CH's Annual Financial Report Filed Within One Month After November 27th or January 28th Deadline Depending Upon The CS's Fiscal Year End Date (June 30th or August 31st)? | No Calculation Involved |
| 5 | * | Was There An Unqualified Opinion In The CH's Annual Financial Report? | No Calculation Involved |
| 6 | * | Did The CH's Annual Financial Report Not Disclose Any Instance(s) Of Material Weaknesses In Internal Controls? | No Calculation Involved |
| 7 | | Are the CS's Liabilities Less Than 80% of Its Assets? | (B/A < .8) Where A = [Total Assets]; B = [Total Liabilities]. |
| 8 | | Did The Comparison Of PEIMS Data To Like Information In The CS's Annual Financial Report Result In An Aggregate Variance Of Less Than 3 Percent Of All Expenses (Data Quality Measure)? | ((A / B) X 100) Where A = [Absolute Value Of All Differences In Expenses In Statement of Activities And PEIMS]; B = [Sum Of Expenses for All Expenses Presented In Statement of Activities] |
| 9 | | Were The CS's Debt Related Expenses Less Than $200 Per Student? (If The CS's Five-Year Percent Change In Students Was A 7% Increase Or More, Then The CS Receives 5 Points) | If ((B – C)/ C) X 100 < 7 % Then Continue Calculation (A / B) Where A = [65XX Object Codes In All Net Asset Accounts (Excluding Expenditure Object Codes 6524 and 6525)]; B = [Number Of Students In Year 5 From Base Year]; C = [Number Of Students In Base Year] |
| 10 | * | Was There No Disclosure In The CH's Annual Audit Report Of Material Noncompliance? | No Calculation Involved |

December 2010

| School FIRST for Charter Schools - Rating Worksheet Calculations Dated December 2010 | | |
|---|---|---|
| | **Indicator** | **Calculation Defined** |
| 11 | Did The CS Have Full Accreditation Status In Relation To Financial Management Practices? (e.g. No Monitor, Conservator, Management Team, Or Board of Managers Assigned) | No Calculation Involved |
| 12 | Was The CS's Aggregate Of Budgeted Expenses Less Than The Aggregate Of Budgeted Total Revenues And Cash And Investments At Beginning of Year? | (A) < (B + C) Where A = [Budgeted Expenses in the Budgetary Comparison Schedule]; B = [Budgeted Revenues In the Budgetary Comparison Schedule]; [C = [Cash And Investments on the Statement of Financial Position At July 1 or September 1 Depending On Fiscal Year End] |
| 13 | Was The CS's Current Ratio For All Net Asset Groups Greater Than Or Equal To 1:1? | If B > 0 Then Continue Calculation As (A / B) Where A = [Current Assets in All Net Asset Groups]; B = [Current Liabilities in All Net Asset Groups] |
| 14 | Was The CS's Administrative Cost Ratio Less Than The Threshold Ratio? (See Ranges Below) | (A>B) Where A = [Acceptable Administrative Cost Ratio]; B = [Administrative Cost Ratio Of The Charter] |
| 15 | Was The Ratio Of Students To Teachers Within The Ranges Shown Below According To CS Size? (See Ranges Below) | (A / B) Where A = [Number Of Students]; B = [Number Of Teacher FTEs] |
| 16 | Was The Ratio Of Students To Total Staff Within The Ranges Shown Below According To CS Size? (See Ranges Below) | (A / B) Where A = [Number Of Students]; B = [Total Staff FTEs] |
| 17 | Would The CS's Existing Assets Cover Two Months Of Operating Expenses? (Liquid Funds Indicator) | (A – B – (C + (D - E)) / ((F - G) / 12) > = 2, Where A = [Total Net Assets]; B = [Permanently Restricted Net Assets]; C = [Land]; D = [Property, Plant & Equipment; E = [Accumulated Depreciation]; F = [Total Expenses]; G = [Depreciation Expense] |
| 18 | Was The Decrease In The CS's Total Net Assets Less Than 20% Over Two Fiscal Years? (Calculation Excludes Depreciation and Amortization) | (A + C) X .80 > (B +D), A = [Net Assets At June 30 or August 31, Depending On Fiscal Year End, Two Fiscal Years Prior]; B= [Net Assets For The Last Fiscal Year]; C=[Accumulated Depreciation, Two Fiscal Years Prior]; D = =[Accumulated Depreciation For The Last Fiscal Year] |
| 19 | Was The CS's Aggregate Total Of Cash And Investments More Than $0? | A > 0 Where A = [Cash and Investments In All Net Asset Groups] |

December 2010

| School FIRST for Charter Schools - Rating Worksheet Calculations Dated December 2010 | | |
|---|---|---|
| | **Indicator** | **Calculation Defined** |
| 20 | Were The CS's Investment Earnings In All Net Asset Groups More Than $5 Per Student? | (A / B > $5) Where A = [Total Investment Earnings]; B = [Number Of Students] |
| 21 | Could The CS Operate For Two Months Without Additional Funds? (Defensive Interval) | (A + B + C) / ((D – E) / 12) Where A = [Cash], B = [Investments], C = [Accounts Receivable], D = [Total Expenses], E = [Depreciation Expense] |

| Indicator 14 | |
|---|---|
| ADA Group | Standard |
| 10,000 and Above | 0.1105 |
| 5,000 to 9,999 | .1250 |
| 1,000 to 4,999 | .1401 |
| 500 to 999 | .1561 |
| Less than 500 | .2654 |
| Sparse | 0.3614 |

| | | Ranges for Ratios | |
|---|---|---|---|
| School Size - Number of Students Between | | Low | High |
| Indicator 15 | | | |
| | <500 | 7.0 | 22 |
| 500 | 999 | 10.0 | 22 |
| 1,000 | 4,999 | 11.5 | 22 |
| 5,000 | 9,999 | 13.0 | 22 |
| =>10,000 | | 13.5 | 22 |
| Indicator 16 | | | |
| | <500 | 5.0 | 14 |
| 500 | 999 | 5.8 | 14 |
| 1,000 | 4,999 | 6.3 | 14 |
| 5,000 | 9,999 | 6.8 | 14 |
| =>10,000 | | 7.0 | 14 |

* In accordance with generally accepted accounting principles established by the Financial Accounting Standards Board (FASB), the financial statements for a non-profit entity must be presented with an aggregate view of the entity as a whole. The indicators with an asterisk are based on the results of the audited financial statements for the entity as a whole. All other indicators are calculated for the financial results presented for the specific-purpose financial statements relating to the operations of the individual charter school.

For Questions Call The Division Of School Financial Audits At (512) 463-9095

December 2010

Figure: 28 TAC §3.3705(f)

**Texas Department of Insurance Notice**

- You are entitled to an adequate network of preferred providers. If you believe that the network is inadequate, you may file a complaint with the Department of Insurance. If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network or out-of-network out-of-pocket maximum, as appropriate.

- You may obtain a current directory of preferred providers at the following website: [website address to be filled out by the insurer or marked inapplicable if the insurer does not maintain an internet website providing information regarding the insurer or the health insurance policies offered by the insurer for use by prospective consumers or current insureds] or by calling [to be filled out by the insurer] for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits. If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.

- You have certain rights under state law to obtain advance estimates:
    - of the amounts that the providers may bill for projected services, from your out-of-network provider; and
    - of the amounts that the insurer may pay for the projected services, from your insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.state.tx.us/consumer/cpmmediation.html.

# IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

## Comptroller of Public Accounts

### Request for Applications

Pursuant to Chapters 403, 447 and 2305, Texas Government Code; and the State Energy Plan (SEP) and related legal authority and regulations, the Comptroller of Public Accounts (Comptroller), State Energy Conservation Office (SECO), announces this Request for Applications (RFA # ET-G1-2011) and Notice of Funding Availability up to $415,000 in grant funding and invites applications from eligible interested public junior colleges or public technical institutes for grant funds for the Energy Training and Education Program of the State Energy Conservation Office (SECO). Eligible entities must be a public junior college or public technical institute and applications must include a twenty percent (20%) match of total project costs. The Comptroller reserves the right to award more than one grant under the terms of this RFA. If a grant award is made under the terms of the RFA, Grantee will be expected to begin performance of the grant agreement on or about April 4, 2011, or as soon thereafter as practical.

Contact: For general questions about these instructions or the application form, please submit your question in writing to William Clay Harris, Assistant General Counsel, Contracts, via facsimile to: (512) 463-3669. This notice is the RFA and will be published after 10:00 a.m. Central Time (CT) on Friday, January 28, 2011 and posted on the Electronic State Business Daily (ESBD) at: http://esbd.cpa.state.tx.us after 10:00 a.m. CT on Friday, January 28, 2011. The application and sample grant agreement will also be posted shortly thereafter on the following website: http://www.seco.cpa.state.tx.us/funding/

Questions and Non-Mandatory Letters of Intent: All written inquiries, questions, and Non-mandatory Letters of Intent must be received at the above-referenced address (Issuing Office), no later than 2:00 p.m. (CT) on Wednesday, February 9, 2011. Prospective applicants are encouraged to fax non-mandatory Letters of Intent and Questions to (512) 463-3669 to ensure timely receipt. Non-mandatory Letters of Intent must be addressed to the attention of Mr. Harris and must be signed by an official of the entity. On or about Friday, February 18, 2011, or as soon thereafter as practical, Comptroller expects to post responses to questions on the ESBD. Late Non-mandatory Letters of Intent and Questions will not be considered under any circumstances. Applicants shall be solely responsible for verifying timely receipt of Non-Mandatory Letters of Intent and Questions in the Issuing Office.

Closing Date: Applications must be delivered in the Issuing Office to the attention of the Assistant General Counsel, Contracts, no later than 2:00 p.m. CT, on Friday, February 25, 2011. Late Applications will not be considered under any circumstances; Applicants shall be solely responsible for verifying time receipt of applications in the Issuing Office.

Evaluation Criteria: Applications will be evaluated under the criteria outlined in the grant application and instructions for this RFA. The Comptroller reserves the right to accept or reject any or all applications submitted. The Comptroller is not obligated to execute a grant agreement on the basis of this notice or the distribution of any RFA. The Comptroller shall not pay for any costs incurred by any entity in responding to this Notice or to the RFA.

The anticipated schedule of events pertaining to this RFA is as follows: Issuance of RFA - January 28, 2011, after 10:00 a.m. CT; Non-Mandatory Letters of Intent and Questions Due - February 9, 2011, 2:00 p.m. CT; Official Responses to Questions posted - February 18, 2011, or as soon thereafter as practical; Applications Due - February 25, 2011 2:00 p.m. CT; Grant Agreement Execution - April 4, 2011, or as soon thereafter as practical; Commencement of Project - April 4, 2011, or as soon thereafter as practical.

TRD-201100222
Pamela G. Smith
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: January 19, 2011

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### Request for Applications

Pursuant to Chapters 403, 447 and 2305, Texas Government Code; and the American Recovery and Reinvestment Act of 2009, Public Law, PL-111-5 (ARRA or Act); and 10 Code of Federal Regulations (CFR) Parts 420 and 600; Executive Order (EO) RP-72 and related legal authority and regulations, the Comptroller of Public Accounts (Comptroller), State Energy Conservation Office (SECO), announces this Request for Applications (RFA # EO-AG1-2011) and Notice of Funding Availability up to $500,000 and invites applications from eligible interested public junior colleges or technical institutes for grant funds to assist in the development of an online A.A.S program in Energy Management that will serve to optimize energy efficiency in publicly-funded institutions. This RFA is offered as part of the Public Education and Outreach Grants of the State Energy Conservation Office (SECO). If a grant award is made under the terms of the RFA, Grantee will be expected to begin performance of the grant agreement on or about April 4, 2011, or as soon thereafter as practical.

Contact: For general questions about these instructions or the application form, please submit your question in writing to Robert Wood, Director of the Local Government Assistance and Economic Development Division, at SECOStimulus@cpa.state.tx.us. The RFA will be published after 10:00 a.m. Central Standard Time (CT) on Friday, January 28, 2011, and posted on the Electronic State Business Daily (ESBD) at: http://esbd.cpa.state.tx.us after 10:00 a.m. CT on Friday, January 28, 2011.

Questions and Non-Mandatory Letters of Intent: All written inquiries, questions, and Non-mandatory Letters of Intent must be received at the above-referenced address no later than 2:00 p.m. (CT) on Wednesday, February 9, 2011. Prospective applicants are encouraged to fax non-mandatory Letters of Intent and Questions to (512) 475-0664 to ensure timely receipt. Non-mandatory Letters of Intent must be addressed to Robert Wood, Director of the Local Government Assistance and Economic Development Division and must be signed by an official of the entity. On or about Friday, February 18, 2011, the Comptroller expects to post responses to questions on the ESBD. Late Non-mandatory Letters of Intent and Questions will not be considered under any circumstances. Applicants shall be solely responsible for verifying

timely receipt of Non-Mandatory Letters of Intent and Questions by the deadline.

Closing Date: Applications must be delivered in the Issuing Office: to the attention of William Clay Harris, Assistant General Counsel, Contracts, Comptroller of Public Accounts, Room 201, LBJ State Office Building, 111 East 17th Street, Austin, Texas 78774, no later than 2:00 p.m. (CT), on Friday, March 4, 2011. Late Applications will not be considered under any circumstances; Applicants shall be solely responsible for verifying time receipt of applications in the Issuing Office.

Evaluation Criteria: Applications will be evaluated under the criteria outlined in the grant application and RFA. The Comptroller reserves the right to accept or reject any or all applications submitted. The Comptroller is not obligated to execute a grant agreement on the basis of this notice or the distribution of any RFA. The Comptroller shall not pay for any costs incurred by any entity in responding to this Notice or to the RFA.

The anticipated schedule of events pertaining to this RFA is as follows: Issuance of RFA - January 28, 2011, after 10:00 a.m. CT; Non-Mandatory Letters of Intent and Questions Due - February 9, 2011, 2:00 p.m. CT; Official Responses to Questions posted - February 18, 2011, or as soon thereafter as practical; Applications Due - March 4, 2011, 2:00 p.m. CT; Grant Agreement Execution - April 4, 2011, or as soon thereafter as practical; Commencement of Project - April 4, 2011, or as soon thereafter as practical.

TRD-201100223
Pamela G. Smith
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: January 19, 2011

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## Office of Consumer Credit Commissioner

### Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.009, and 304.003, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 01/24/11 - 01/30/11 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 01/24/11 - 01/30/11 is 18% for Commercial over $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 02/01/11 - 02/28/11 is 5.00% for Consumer/Agricultural/Commercial/credit through $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 02/01/11 - 02/28/11 is 5.00% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

TRD-201100188
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: January 18, 2011

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## Credit Union Department

### Application to Amend Articles of Incorporation

Notice is given that the following application has been filed with the Credit Union Department (Department) and is under consideration:

An application for a name change was received from Auto Parts Employees Credit Union, Fort Worth, Texas. The credit union is proposing to change its name to Everman Parkway Credit Union.

Comments or a request for a meeting by any interested party relating to an application must be submitted in writing within 30 days from the date of this publication. Any written comments must provide all information that the interested party wishes the Department to consider in evaluating the application. All information received will be weighed during consideration of the merits of an application. Comments or a request for a meeting should be addressed to the Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699.

TRD-201100210
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 19, 2011

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### Applications to Expand Field of Membership

Notice is given that the following applications have been filed with the Credit Union Department (Department) and are under consideration:

An application was received from InvesTex Credit Union, Houston, Texas to expand its field of membership. The proposal would permit employees of Al's Formal Wear who work in or are paid or supervised from Houston, Texas, to be eligible for membership in the credit union.

An application was received from America's Credit Union, Garland, Texas to expand its field of membership. The proposal would permit persons who reside or work in Greene, Christian, and Webster Counties, Missouri, to be eligible for membership in the credit union.

Comments or a request for a meeting by any interested party relating to an application must be submitted in writing within 30 days from the date of this publication. Credit unions that wish to comment on any application must also complete a Notice of Protest form. The form may be obtained by contacting the Department at (512) 837-9236 or downloading the form at http://www.tcud.state.tx.us/applications.html. Any written comments must provide all information that the interested party wishes the Department to consider in evaluating the application. All information received will be weighed during consideration of the merits of an application. Comments or a request for a meeting should be addressed to the Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699.

TRD-201100209
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 19, 2011

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### Notice of Final Action Taken

In accordance with the provisions of 7 TAC §91.103, the Credit Union Department provides notice of the final action taken on the following applications:

Application to Expand Field of Membership - Approved

Texas Dow Employees Credit Union (#5), Lake Jackson, Texas - See *Texas Register* issue, dated August 29, 2008.

Application for a Merger or Consolidation - Approved

East Texas Professional Credit Union (Longview) and Synergy Eastex Federal Credit Union (Longview) - See *Texas Register* issue, dated September 24, 2010.

TRD-201100211
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 19, 2011

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## Texas Education Agency

### Request for Applications Concerning Secondary Mathematics Teacher Support Program, 2011-2012

Eligible Applicants. The Texas Education Agency (TEA) is requesting applications under Request for Applications (RFA) #701-11-103 from eligible high-need local educational agencies (LEAs), mathematics departments of Texas institutions of higher education (IHEs), or regional education service centers (ESCs). Applicants must form partnerships that include, at a minimum, a high-need LEA and a mathematics department of an IHE. Eligible partnership arrangements may also include additional high-need LEAs, non-high-need LEAs, open-enrollment charter schools, private nonprofit schools, nonprofit organizations, and/or an ESC. High-need LEAs are defined as LEAs in which at least 40% of the students qualify for free or reduced-price lunch (based on the Texas Department of Agriculture 2010-2011 school year data). An eligibility list will be published with the RFA.

Description. The purpose of the Secondary Mathematics Teacher Support Program grant is to promote college and career readiness at eligible school districts by providing assistance in implementing programs that provide high-need school districts and their campuses with strategies and models to improve the content knowledge and instructional expertise of mathematics teachers at the middle, junior high, or high school levels. The goals of the grant program are to plan, design, and implement programs to support the improvement of secondary mathematics teachers' content knowledge and instructional expertise; implement a research-based program with a strong emphasis on improving mathematics teachers' abilities to increase at-risk student performance in mathematics; institute a rigorous and engaging professional development and support program that redesigns structural and collaborative practices for mathematics teachers; develop the skills and knowledge of school leaders in the area of mathematics instruction; and provide models of excellence in coaching secondary mathematics teachers to improve their knowledge and expertise. Grant recipients must design a Secondary Mathematics Teacher Support Program that includes, at a minimum, a required partnership between a high-need LEA and an IHE. Any other qualified partners may be added.

Dates of Project. The Secondary Mathematics Teacher Support Program will be implemented during the 2010-2011 and 2011-2012 school years. Applicants should plan for a starting date of no earlier than June 1, 2011, and an ending date of no later than July 31, 2012.

Project Amount. Funding will be provided for approximately 20 projects totaling approximately $2.8 million. Each applicant may apply for a maximum possible grant award of $250,000 for the 2011-2012 grant period. Continuation and expansion funding may be made available based on evaluation results of the program and budget approval by the commissioner of education and appropriations by Congress. This project is funded 100% from federal funds.

Selection Criteria. Applications will be selected based on the ability of each applicant to carry out all requirements contained in the RFA. Reviewers will evaluate applications based on the overall quality and validity of the proposed grant programs and the extent to which the applications address the primary objectives and intent of the project. Applications must address each requirement as specified in the RFA to be considered for funding. TEA reserves the right to select from the highest-ranking applications those that address all requirements in the RFA. Consideration (or priority) will be given to applicants with a high dropout rate, as specified in the RFA.

TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TEA to pay any costs before an application is approved. The issuance of this RFA does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Requesting the Application. RFAs are no longer available in print. The announcement letter and complete RFA will be posted on the TEA website at http://burleson.tea.state.tx.us/GrantOpportunities/forms for viewing and downloading. In the "Select Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view all documents that pertain to this RFA.

Further Information. For clarifying information about the RFA, contact Dale Fowler, Division of State Initiatives, Texas Education Agency, (512) 936-6060. In order to assure that no prospective applicant may obtain a competitive advantage because of acquisition of information unknown to other prospective applicants, any information that is different from or in addition to information provided in the RFA will be provided only in response to written inquiries. Copies of all such inquiries and the written answers thereto will be posted on the TEA website in the format of Frequently Asked Questions (FAQs) at http://burleson.tea.state.tx.us/GrantOpportunities/forms. In the "Select Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view all documents that pertain to this RFA.

Deadline for Receipt of Applications. Applications must be received in the TEA Document Control Center by 5:00 p.m. (Central Time), Tuesday, March 1, 2011, to be eligible to be considered for funding.

TRD-201100219
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: January 19, 2011

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## Texas Commission on Environmental Quality

### Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 28, 2011.** Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is

inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on February 28, 2011.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Aqua Development, Inc.; DOCKET NUMBER: 2010-1497-MWD-E; IDENTIFIER: RN102076841; LOCATION: Montgomery County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 Texas Administrative Code (TAC) §305.125(1), Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014013001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to comply with permitted effluent limitations for total suspended solids (TSS) and ammonia nitrogen ($NH_3N$); PENALTY: $2,800; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3100; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(2) COMPANY: BUCKLEY OIL COMPANY; DOCKET NUMBER: 2010-1343-DCL-E; IDENTIFIER: RN103058939; LOCATION: Wichita Falls, Wichita County; TYPE OF FACILITY: chemical distribution; RULE VIOLATED: 30 TAC §337.4(b), by failing to prevent the sale, delivery, or distribution of any dry cleaning solvent to a facility that does not have a valid, current dry cleaning registration certificate; PENALTY: $12,600; ENFORCEMENT COORDINATOR: Tate Barrett, (713) 767-3500; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(3) COMPANY: Celanese Limited; DOCKET NUMBER: 2010-1559-AIR-E; IDENTIFIER: RN100227016; LOCATION: Pasadena, Harris County; TYPE OF FACILITY: chemical plant; RULE VIOLATED: 30 TAC §116.115(c), Permit Number 55046, Special Condition (SC) Number 1, and Texas Health and Safety Code (THSC), §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $3,975; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(4) COMPANY: Chevron Phillips Chemical Company, LP; DOCKET NUMBER: 2010-0709-AIR-E; IDENTIFIER: RN100825249; LOCATION: Old Ocean, Brazoria County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §101.20(3) and §116.715(a), Flexible Permit Numbers 22690 and PSD-TX-751M1, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; 30 TAC §113.500, 40 Code of Federal Regulations (CFR) §63.997(c)(1), and THSC, §382.085(b), by failing to conduct a flare compliance test or submit a flare performance test waiver request; 30 TAC §113.520, 40 CFR §63.1110(e)(2), and THSC, §382.085(b), by failing to submit the periodic report for Unit 12 which is subject to 40 CFR Part 63, Subpart UU; 30 TAC §113.560, 40 CFR §63.1111(a) and (b), and THSC, §382.085(b), by failing to submit the startup, shutdown, and malfunction (SSM) period report and a SSM plan for Unit 12; 30 TAC §113.890, 40 CFR §63.2515(b) and §63.2520(a), and THSC, §382.085(b), by failing to submit the initial notification and the notice of compliance status (NOCS) report for Units 10ABC, 10D, and 21; 30 TAC §113.560, 40 CFR §63.1110(c)(1) and (d)(2), and THSC, §382.085(b), by failing to submit the initial notification and the NOCS report for Unit 12; 30 TAC §113.550, 40 CFR §63.1086(a) and §63.1089(a), and THSC, §382.085(b), by failing to utilize the approved method of monitoring for leaks to the cooling water for Unit 12; and 30 TAC §113.520, 40 CFR §63.1022(a), and THSC, §382.085(b), by failing to identify Unit 12 as being subject to 40 CFR Part 63, Subpart UU; PENALTY: $235,330; Supplemental Environmental Project (SEP) offset amount of $94,132 applied to Texas Association of Resource Conservation and Development Areas, Inc. (RC&D) - Abandoned Tire Clean-Up; ENFORCEMENT COORDINATOR: Nadia Hameed, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(5) COMPANY: Henry R. Garza dba Cielo Azul Ranch; DOCKET NUMBER: 2010-1171-PWS-E; IDENTIFIER: RN101217792; LOCATION: Wimberley, Hays County TYPE OF FACILITY: mobile home park; RULE VIOLATED: 30 TAC §290.271(b) and §290.274(a) and (c), by failing to mail or directly deliver one copy of the consumer confidence report (CCR) to each bill paying customer by July 1 of each year and by failing to submit to the TCEQ by July 1 of each year a copy of the annual CCR and certification that the CCR has been distributed to the customers of the facility and that the information in the CCR is correct and consistent with compliance monitoring data; PENALTY: $348; ENFORCEMENT COORDINATOR: Amanda Henry, (713) 767-3500; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(6) COMPANY: City of Daingerfield; DOCKET NUMBER: 2010-1925-MWD-E; IDENTIFIER: RN102177953; LOCATION: Morris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010499001, Final Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with permitted effluent limits for flow, $NH_3N$, and TSS; PENALTY: $4,260; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(7) COMPANY: Davis Gas Processing, Inc.; DOCKET NUMBER: 2010-1583-AIR-E; IDENTIFIER: RN100245182; LOCATION: Crockett County; TYPE OF FACILITY: natural gas processing plant; RULE VIOLATED: 30 TAC §122.146(2), Federal Operating Permit (FOP) Number O-03024, Special Terms and Conditions (STC) Number 8, and THSC, §382.085(b), by failing to submit a permit compliance certification; PENALTY: $3,125; ENFORCEMENT COORDINATOR: Raymond Marlow, (409) 898-3838; REGIONAL OFFICE: 3300 North A Street, Building 4-107, Midland, Texas 79705-5406, (432) 570-1359.

(8) COMPANY: E.I. du Pont de Nemours and Company; DOCKET NUMBER: 2010-1556-AIR-E; IDENTIFIER: RN100216035; LOCATION: Nederland, Jefferson County; TYPE OF FACILITY: petrochemical plant; RULE VIOLATED: 30 TAC §116.115(b)(2)(F) and (c) and §122.143(4), Air Permit Number 4351, SC Number 1, FOP Number O-01961, General Terms and Conditions (GTC) and SC Number 16, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $27,675; ENFORCEMENT COORDINATOR: Raymond Marlow, (409) 898-3838; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(9) COMPANY: Explorer Pipeline Company; DOCKET NUMBER: 2010-1671-IWD-E; IDENTIFIER: RN104860044; LOCATION:

Anderson County; TYPE OF FACILITY: refined petroleum pipeline with an associated groundwater remediation treatment system; RULE VIOLATED: 30 TAC §305.125(1), TPDES General Permit Number TXG830179, Part III Section A. Effluent Limitations, and the Code, §26.121, by failing to comply with permitted effluent limits for benzene and methyl tert-butyl ether; PENALTY: $7,125; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5800; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(10) COMPANY: ExxonMobil Oil Corporation; DOCKET NUMBER: 2010-1524-AIR-E; IDENTIFIER: RN100211903; LOCATION: Beaumont, Jefferson County; TYPE OF FACILITY: polyethylene plastic manufacturing; RULE VIOLATED: 30 TAC §101.201(a)(1)(B) and §122.143(4), FOP Number O-01243, SC Number 2(F), and THSC, §382.085(b), by failing to report an emissions event no later than 24 hours after discovery; and 30 TAC §116.115(b)(2)(F) and (c) and §122.143(4), FOP Number O-01243, SC Number 10, Air Permit Number 6860, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $4,082; SEP offset amount of $1,633 applied to Southeast Texas Regional Planning Commission - *Meteorological and Air Monitoring Network;* ENFORCEMENT COORDINATOR: Audra Benoit, (409) 898-3838; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(11) COMPANY: Happy Hill Farm Children's Home, Inc. dba Happy Hill Farm Academy; DOCKET NUMBER: 2010-1209-MWD-E; IDENTIFIER: RN101529055; LOCATION: Somervell County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.65 and §305.125(2) and the Code, §26.121(a), by failing to maintain authorization for the discharge of wastewater; PENALTY: $15,300; ENFORCEMENT COORDINATOR: Heather Brister, (254) 751-0335; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(12) COMPANY: Harris County Water Control and Improvement District Number 89; DOCKET NUMBER: 2010-1457-MWD-E; IDENTIFIER: RN101527596; LOCATION: Harris County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1) and (5) and TPDES Permit Number WQ0012939001, Operational Requirements Number 1, by failing to maintain adequate safeguards to prevent the discharge of untreated or inadequately treated wastes during electrical power failures; 30 TAC §305.125(1) and (5) and TPDES Permit Number WQ0012939001, Operational Requirements Number 1, by failing to ensure that the facility and all of its systems of collection, treatment, and disposal are properly operated and maintained; 30 TAC §305.125(1) and §319.11(d) and TPDES Permit Number WQ0012939001, Monitoring and Reporting Requirements Number 2 and Operational Requirements Number 5, by failing to measure flow in an accurate and representative manner; 30 TAC §217.6 and §305.125(1) and TPDES Permit Number WQ0012939001, Other Requirements Number 7, by failing to submit a summary transmittal letter prior to facility expansion; and 30 TAC §305.125(1) and (5) and TPDES Permit Number WQ0012939001, Operational Requirements Number 1, by failing to maintain the onsite lift station to prevent an accumulation of grease; PENALTY: $22,660; ENFORCEMENT COORDINATOR: Evette Alvarado, (512) 239-2573; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(13) COMPANY: HIMCHULI INTERNATIONAL, LLC dba Easy Mart; DOCKET NUMBER: 2010-1701-PST-E; IDENTIFIER: RN102517489; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to ensure that all underground storage tanks (USTs) are monitored in a manner which will detect a release at a frequency of at least once every month; PENALTY: $1,975; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(14) COMPANY: Holly Park Marina, Inc.; DOCKET NUMBER: 2010-1637-SLG-E; IDENTIFIER: RN102928405; LOCATION: Milam, Sabine; TYPE OF FACILITY: marina/campground with an associated onsite sewage facilities sludge transportation business; RULE VIOLATED: 30 TAC §312.142(a), by failing to obtain a sludge transporter registration prior to commencing operations; and 30 TAC §312.143 and the Code, §26.121(a)(1), by failing to deposit septic tank waste at a facility authorized to receive such wastes; PENALTY: $1,400; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(15) COMPANY: City of Hughes Springs; DOCKET NUMBER: 2010-1821-MWD-E; IDENTIFIER: RN101919686; LOCATION: Hughes Springs, Cass; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010415001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to comply with permitted effluent limits for $NH_3N$; PENALTY: $1,300; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(16) COMPANY: Huntsman Petrochemical, LLC; DOCKET NUMBER: 2010-1422-AIR-E; IDENTIFIER: RN100219252; LOCATION: Port Neches, Jefferson; TYPE OF FACILITY: petrochemical plant; RULE VIOLATED: 30 TAC §116.115(c) and §122.143(4), Air Permit Number 19823, SC Numbers 1 and 26, FOP Number O-02288, STC Number 16, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $9,975; SEP offset amount of $3,990 applied to Southeast Texas Regional Planning Commission - Southeast Texas Regional Air Monitoring Network Ambient Air Monitoring Station; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(17) COMPANY: Elizabeth Perez dba JD's Kwik Stop; DOCKET NUMBER: 2010-1641-PWS-E; IDENTIFIER: RN105486518; LOCATION: Laredo, Webb County; TYPE OF FACILITY: public water supply (PWS); RULE VIOLATED: 30 TAC §290.39(e)(1) and (h)(1) and THSC, §341.035(2), by failing to submit plans and specifications prepared under the direction of a licensed professional engineer and receive written approval of the plans and specifications; 30 TAC §290.46(d)(2)(A) and §290.110(b)(4) and THSC, §341.0315(c), by failing to operate the disinfection equipment to maintain a minimum disinfectant residual of 0.2 milligrams per liter (mg/L) free chlorine; and 30 TAC §290.41(c)(3)(A), by failing to submit well completion data to the commission for review and approval; PENALTY: $501; ENFORCEMENT COORDINATOR: Amanda Henry, (713) 767-3500; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(18) COMPANY: JYKM UNION, INC. dba Thrall Food Store; DOCKET NUMBER: 2010-1680-PST-E; IDENTIFIER: RN102868189; LOCATION: Thrall, Williamson County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.7(d)(3), by failing to notify the agency of any change or additional information regarding the USTs; 30 TAC §334.8(c)(5)(C), by failing to ensure that a legible tag, label, or marking with the tank number is permanently applied upon or affixed to either the top of the fill tube or to a nonremovable point in the immediate area of the fill tube; 30 TAC §334.42(i), by failing

to inspect all sumps, manways, overspill containers, or catchment basins associated with a UST system; and 30 TAC §115.221 and THSC, §382.085(b), by failing to control displaced vapors from a gasoline storage container located at a motor vehicle fuel dispensing station; PENALTY: $4,105; ENFORCEMENT COORDINATOR: Tate Barrett, (713) 767-3500; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(19) COMPANY: Monarch Utilities I, L.P.; DOCKET NUMBER: 2010-1808-MWD-E; IDENTIFIER: RN102287125; LOCATION: Henderson County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0011506001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with permitted effluent limitations for $NH_3N$; PENALTY: $3,170; ENFORCEMENT COORDINATOR: JR Cao, (512) 239-2543; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(20) COMPANY: Overseas Enterprises USA, Inc. dba Gateway Travel Plaza; DOCKET NUMBER: 2010-1372-PST-E; IDENTIFIER: RN101743730; LOCATION: Vidor, Orange County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment, vapor space manifolding, and dynamic back pressure; PENALTY: $9,339; ENFORCEMENT COORDINATOR: Elvia Maske, (512) 239-0789; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(21) COMPANY: Polk County; DOCKET NUMBER: 2010-1477-AIR-E; IDENTIFIER: RN102668654; LOCATION: Leggett, Polk County; TYPE OF FACILITY: municipal landfill; RULE VIOLATED: 30 TAC §122.143(4) and §122.145(2)(B), FOP Number O-02686, General Operating Permit (GOP) Number 517, Site-wide Requirements (SWR) Number (b)(2), by failing to submit semiannual deviation reports; 30 TAC §§106.8(c)(2) and (4), 122.143(4), and 122.144(1), FOP Number O-02686, GOP Number 517, SWR Numbers (b)(2) and (b)(5)(C)ii, and THSC, §382.085(b), by failing to maintain the required emissions data and/or records to verify eligibility for the claimed permit by rules for the site; 30 TAC §§106.454(1)(A)(ii), 122.143(4), and 122.144(1), FOP Number O-02686, GOP Number 517, SWR Numbers (b)(2) and (b)(5)(D)xxi, by failing to maintain, on a monthly basis, inspection and solvent use records for the manufacturing shop degreasing unit; 30 TAC §106.454(1)(E) and §122.143(4), FOP Number O-02686, GOP Number 517, SWR Numbers (b)(2) and (b)(5)(D)xxi, and THSC, §382.085(b), by failing to post a permanent and conspicuous label summarizing proper operating procedures to minimize emissions on or near the degreaser; 30 TAC §122.143(4) and §122.146(1), FOP Number O-02686, GOP Number 517, SWR Number (b)(2), and THSC, §382.085(b), by failing to report all deviations and accurately certify compliance in the annual compliance certification; and 30 TAC §§111.111(a)(4)(A)(ii), 122.143(4), and 122.144(1), FOP Number O-02686, GOP Number 517, SWR Number (b)(2), and THSC, §382.085(b), by failing to maintain records of the daily flare observations; PENALTY: $9,110; ENFORCEMENT COORDINATOR: Elvia Maske, (512) 239-0789; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(22) COMPANY: Shell Chemical, LP; DOCKET NUMBER: 2010-1331-AIR-E; IDENTIFIER: RN100211879; LOCATION: Deer Park, Harris County; TYPE OF FACILITY: chemical plant; RULE VIOLATED: 30 TAC §101.20(3) and §116.115(c), Permit Numbers 3219 and PSD-TX-974, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; 30 TAC §101.201(a)(1)(b) and (c) and THSC, §382.085(b), by failing to submit the initial notification for Incident Number 136726 within 24 hours after the discovery of the event and by failing to submit the final report within 14 days after the end of the event; PENALTY: $21,346; SEP offset amount of $10,673 applied to Barbers Hill Independent School District - Alternative Fueled Vehicle and Equipment Program; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(23) COMPANY: William Donald Smith dba Sunset Mobile Home Park 1 dba Sunset Mobile Home Park 2 dba Kingmont Mobile Home Park and dba Tallows Mobile Home Park; DOCKET NUMBER: 2010-1815-UTL-E; IDENTIFIER: RN102691938, RN101218030, RN101283331, and RN101219871; LOCATION: Harris County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.39(o)(1) and §291.162(a) and (j) and the Code, §13.1395(b)(2), by failing to adopt and submit to the executive director for approval by the extension deadline of June 1, 2010, an emergency preparedness plan; PENALTY: $1,278; ENFORCEMENT COORDINATOR: Kelly Wisian, (512) 239-2570; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(24) COMPANY: Texas Department of Aging and Disability Services; DOCKET NUMBER: 2010-1505-MWD-E; IDENTIFIER: RN102335999; LOCATION: Tom Green County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(4), Permit Number WQ0010634001, Permit Conditions Number 2.g., and the Code, §26.121(c), by failing to prevent unauthorized discharges of wastewater; 30 TAC §305.125(1), Permit Number WQ0010634001, Effluent Limitations and Monitoring Requirements Number A, and the Code, §26.121, by failing to maintain a total chlorine residual concentration of at least one mg/L in the final effluent; 30 TAC §319.11(b) and Permit Number WQ0010634001, Monitoring Requirements Number 2, by failing to properly preserve a biochemical oxygen demand sample at the correct temperature; 30 TAC §319.7(a) and Permit Number WQ0010634001, Monitoring Requirements Number 3.c., by failing to maintain adequate records of monitoring activities; 30 TAC §319.6 and §319.9(d), by failing to perform and record quality assurance checks for total chlorine residual monitoring; and 30 TAC §305.125(1) and Permit Number WQ0010634001, Special Provisions Number 15, by failing to provide documentation showing the effluent storage ponds are adequately lined to control seepage; PENALTY: $5,660; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5800; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(25) COMPANY: TOTAL Petrochemicals USA, Inc.; DOCKET NUMBER: 2010-1675-AIR-E; IDENTIFIER: RN100212109; LOCATION: La Porte, Harris County; TYPE OF FACILITY: petrochemical plant; RULE VIOLATED: 30 TAC §116.115(c), New Source Review Permit Number 3908B, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $10,000; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(26) COMPANY: Town of Little Elm; DOCKET NUMBER: 2010-0249-MWD-E; IDENTIFIER: RN102909124; LOCATION: Denton County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0011600001, Interim Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to comply with permitted effluent limits for five-day carbonaceous biochemical oxygen demand, $NH_3N$, and total phosphorus; PENALTY: $12,225; SEP offset amount of $9,780 applied to conducting two city-wide pharmaceutical collection events to provide city-wide collection and proper disposal of pharmaceuticals; ENFORCEMENT COORDINA-

TOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(27) COMPANY: Turner Industries Group, L.L.C.; DOCKET NUMBER: 2009-1616-AIR-E; IDENTIFIER: RN103063228; LOCATION: Paris, Lamar County; TYPE OF FACILITY: pipe manufacturing plant; RULE VIOLATED: 30 TAC §122.143(4) and §122.146(1), FOP Number O-02388, GTC, and THSC, §382.085(b), by failing to submit the required Title V compliance certifications; 30 TAC §122.143(4) and §122.144(1), FOP Number O-02388, STC Number 3, and THSC, §382.085(b), by failing to maintain records of quarterly visible emissions observations; and 30 TAC §116.115(b)(2)(F) and §122.143(4), Air Permit Number 41075, General Condition Number 8, FOP Number O-02388, STC Number 6, and THSC, §382.085(b), by failing to meet the emissions limits for hazardous air pollutants; PENALTY: $18,125; SEP offset amount of $7,250 applied to RC&D - Abandoned Tire Clean-Up; ENFORCEMENT COORDINATOR: Raymond Marlow, (409) 898-3838; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(28) COMPANY: Tyson Poultry, Inc.; DOCKET NUMBER: 2009-0601-AIR-E; IDENTIFIER: RN102771177; LOCATION: Tenaha, Shelby County; TYPE OF FACILITY: feed mill; RULE VIOLATED: 30 TAC §116.110(a)(1) and THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization for all emission sources; 30 TAC §116.115(c), Air Permit Number 3797, SC Number 7B, and THSC, §382.085(b), by failing to maintain records necessary to determine compliance with operating conditions of the permit; and 30 TAC §116.115(c), Air Permit Number 3797, General Condition Number 9 and SC Number 1, and THSC, §382.085(b), by failing to operate air pollution emissions capture and abatement equipment properly during normal operations; PENALTY: $15,753; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 898-3838; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(29) COMPANY: Wellborn Special Utility District; DOCKET NUMBER: 2010-1670-MWD-E; IDENTIFIER: RN101515039; LOCATION: Brazos County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0013850001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with permitted effluent limitations for TSS and $NH_3N$; and 30 TAC §305.125(1) and (17) and TPDES Permit Number WQ0013850001, Sludge Provisions, by failing to submit an annual sludge report; PENALTY: $5,694; ENFORCEMENT COORDINATOR: Evette Alvarado, (512) 239-2573; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(30) COMPANY: WESTOREM FOODMART, LLC dba Yours Citgo Mart; DOCKET NUMBER: 2010-1459-PST-E; IDENTIFIER: RN105171110; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.246(1) and THSC, §382.085(b), by failing to maintain a copy of the California Air Resources Board Executive Order for the Stage II vapor recovery system; and 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II vapor space manifolding and dynamic back pressure; PENALTY: $8,035; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-201100173
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 18, 2011

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## Notice of Opportunity to Request a Public Meeting for a New Municipal Solid Waste Facility Registration Application No. 40254

APPLICATION. WM Resource Recovery & Recycling Center, 7505 State Highway 65, P.O. Box 460, Anahuac, Chambers County, TX 77514, has applied to the Texas Commission on Environmental Quality (TCEQ) for a proposed Registration (No. 40254), to construct and operate a Type V municipal solid waste Transfer Station. The proposed facility, WM Resource Recovery & Recycling Center, will be located at 7505 State Highway 65, Anahuac, TX 77514, in Chambers County. This facility is requesting authorization to process, transfer, and recycle municipal solid waste which includes medical waste. The registration application is available for viewing and copying at the Chambers County Public Library, 202 Cummings Street, Anahuac, TX 77514 and may be viewed online at www.wm.com/texas/permits.asp

The TCEQ executive director has reviewed this action for consistency with the goals and policies of the Texas Coastal Management Program (CMP) in accordance with the regulations of the Coastal Coordination Council and has determined that the action is consistent with the applicable CMP goals and policies.

PUBLIC COMMENT/PUBLIC MEETING. Written public comments or written requests for a public meeting must be submitted to the Office of Chief Clerk at the address included in the information section below. Comments may also be received if a public meeting is held on the facility. A public meeting will be held by the executive director if requested by a member of the legislature who represents the general area where the development is to be located, or if there is a substantial public interest in the proposed development. The purpose of the public meeting is for the public to provide input for consideration by the commission, and for the applicant and the commission staff to provide information to the public. A public meeting is not a contested case hearing. The executive director will review and consider public comments and written requests for a public meeting submitted prior to the notice of final determination. The executive director is not required to file a response to comments.

EXECUTIVE DIRECTOR ACTION. The executive director shall, after review of an application for registration, determine if the application will be approved or denied in whole or in part. If the executive director acts on an application, the chief clerk shall mail or otherwise transmit notice of the action and an explanation of the opportunity to file a motion to reconsider the executive director's decision. The chief clerk shall mail this notice to the owner and operator, the public interest counsel, to adjacent landowners as shown on the required land ownership map and landowners list, and to other persons who timely filed public comment in response to public notice. Not all persons on the mailing list for this notice will receive the notice letter from the Office of the Chief Clerk.

INFORMATION. Written public comments or requests to be placed on the permanent mailing list for this application should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087 or electronically submitted to http://www10.tceq.state.tx.us/epic/ecmnts/. Individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us. Further information may also be obtained from WM Resource Recovery & Recycling Center at the address stated above or by calling Dr. Linda D. Lee, Vice President, at (713) 394-2349. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201100220
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: January 19, 2011

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## Notice of Request for Nominations to Fill Positions on the Pollution Prevention Advisory Committee

The Texas Commission on Environmental Quality (commission) is soliciting nominations to fill four positions on the Pollution Prevention Advisory Committee (PPAC). The legislatively created advisory committee, established under Texas Health and Safety Code, §361.0215, advises the commission on the state's policy and goals for pollution prevention and waste minimization.

The PPAC is composed of nine voting members who offer a balanced representation of environmental and public interest groups and the regulated community.

Individuals interested in being considered by the commission should submit a one-page letter of interest and brief resume or biography. All nominations must be received by the commission no later than 5:00 p.m. February 11, 2011.

The PPAC advises the commission on: the appropriate organization of state agencies and the financial and technical resources required to aid the state in its efforts to promote waste reduction and minimization; the development of public awareness programs to educate citizens about hazardous waste and the appropriate disposal of hazardous waste and hazardous materials that are used and collected by households; the provision of technical assistance to local governments for the development of waste management strategies designed to assist small quantity generators of hazardous waste; other possible programs to more effectively implement the state's hierarchy of preferred waste management technologies as set forth in Texas Health and Safety Code, §361.023(a); and recycling market development implementation, under the authority provided in Texas Health and Safety Code, §361.423.

The PPAC operates under the requirements of 30 Texas Administrative Code Chapter 5, Advisory Committees and Groups. The 79th Legislature, 2005, authorized reimbursement for committee members' travel expenses.

The commissioners invite nominations for the following positions. Nominations may be made for oneself. Each nomination should include a brief cover letter and biographical summary that includes the individual's experience and qualifications, and an agreement to serve on the committee if appointed. Please submit nomination(s) for consideration by the commission for the following four positions: representative(s) from the regulated community (to fill four-year terms that expire on August 31, 2014); representative(s) from environmental or public interest groups (to fill four-year terms that expire on August 31, 2014). Written nominations must be received in the Small Business and Environmental Assistance Division Office by 5:00 p.m. on February 11, 2011. Nominations should be directed to: Mary Kelley, Pollution Prevention and Education Section (MC 113), Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087. They can also be sent via e-mail to *recycle@tceq.state.tx.us* or they can be faxed to (512) 239-1065. Documents can be submitted via hand delivery to the Pollution Prevention and Education Section, MC 113, 12100 Park 35 Circle, Building F, Suite 1301, Austin, Texas 78753.

Questions regarding the PPAC and the current nominations process can be directed to Mary Kelley at (512) 239-6324. For more information, visit the web site at http://www.tceq.texas.gov/assistance/P2Recycle/ppac/PollutionPreventionAdvisoryCommittee.html.

TRD-201100174
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: January 18, 2011

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## Notice of Water Quality Applications

The following notice was issued on January 10, 2011 through January 13, 2011.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

OXY VINYLS, L.P. which operates the Oxy Vinyls Battleground Facility, a caustic, chlorine, and hydrogen manufacturing plant, has applied to the Texas Commission on Environmental Quality (TCEQ) for a major amendment to TPDES Permit No. WQ0001539000 requesting: (a) the removal of effluent limitations and monitoring requirements for total aluminum at Outfall 001, (b) an increase in the effluent limitation for total copper, total lead, and total zinc at Outfall 001, (c) authorization to discharge hydrostatic test water, demineralizer and reverse osmosis wastewaters, and water treatment filter backwash via Outfall 001, (d) authorization to discharge non-contact cooling water, potable water, process wastewater, and utility wastewater intermittently via Outfall 002, (e) inclusion of the definition of utility wastewaters in the Other Requirements section, and (f) updating of the description of the facility location. The current permit authorizes the discharge of treated process wastewater, utility wastewaters, storm water, and previously monitored effluent (domestic wastewater via Outfall 201) at a daily average flow not to exceed 2,150,000 gallons per day via Outfall 001 and the discharge of storm water on an intermittent and flow variable basis via Outfall 002. The facility is located on the east side of State Park Road 1836 (Vista Road) approximately 1,000 feet northeast of its intersection with State Highway 134 (Independence Parkway) in the City of La Porte, Harris County, Texas 77571. The TCEQ Executive Director has reviewed this action for consistency with the Texas Coastal Management Program goals and policies in accordance with the regulations of the Coastal Coordination Council, and has determined that the action is consistent with the applicable CMP goals and policies.

GULBRANDSEN TECHNOLOGIES, INC. which operates Gulbrandsen Technologies La Porte facility, has applied for a major amendment without renewal to TPDES Permit No. WQ0001785000 to remove the authorization to discharge via Outfall 002 and internal Outfall 101; to increase the daily average effluent flow to 200,000 gallons per day and the daily maximum flow to 300,000 gallons per day via Outfall 001; and to remove Other Requirement No. 13. from the existing permit. The current permit authorizes the discharge of process wastewater, utility wastewater, storm water, and previously monitored effluents (treated domestic wastewater) at a daily average flow not to exceed 100,000 gallons per day via Outfall 001, and the discharge of storm water on an intermittent and flow variable basis via Outfall 002. The facility is located north of and adjacent to Strang Road, approximately 0.5 mile east of the intersection of Strang Road and U.S. Highway 225 in the City of La Porte, Harris County, Texas 77571.

SOUTHWESTERN ELECTRIC POWER COMPANY which operates the Welsh Power Plant, has applied for a renewal of TPDES Permit No. WQ0001811000, which authorizes the discharge of low volume wastes, ash transport water, coal pile runoff, storm water, and previously monitored effluents (metal cleaning wastes via Internal Outfall 101) at a daily average flow not to exceed 20,000,000 gallons per day via Outfall 001; and once through cooling water, storm water, and previously monitored effluent (treated domestic wastewater via Internal Outfall 103) at a daily average flow not to exceed 1,425,000,000 gallons per day via Outfall 003. The facility is located approximately two miles northwest of the Town of Cason and approximately one and one half miles north of State Highway 11, Titus County, Texas 75686.

PLAINVIEW BIOENERGY, LLC which operates Plainview BioEnergy, has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0004935000, to authorize the discharge of boiler and cooling tower blowdown, reverse osmosis reject water and water softener regeneration water at a daily average flow not to exceed 570,000 gallons per day via Outfall 001. This permit replaces TPDES Permit No. WQ0004829000 which expired March 1, 2010. The facility is located in the northwest quadrant of the intersection of State Road 789 and US Highway 70, 3.5 miles east of Plainview, Hale County, Texas 79072.

CITY OF ROCKPORT has applied for a minor amendment to the Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0010054001 to authorize the discharge of treated domestic wastewater at an annual average flow not to exceed 2,000,000 gallons per day in the interim phase. The existing permit authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,500,000 gallons per day. The current permit also authorizes the disposal of treated domestic wastewater via irrigation of 200 acres of the Rockport Country Club Golf Course. The facility is located on the west side of Farm-to-Market Road 2165, approximately 1,200 feet south of the intersection of Farm-to-Market Road 2165 and Enterprise Boulevard in Aransas County, Texas 78732.

CITY OF EMORY has applied to the Texas Commission on Environmental Quality (TCEQ) for a renewal of TPDES Permit No. WQ0010082002, which authorizes the discharge of treated filter backwash effluent from a water treatment plant at a daily average flow not to exceed 44,000 gallons per day. The facility is located 5,000 feet southwest of the intersection of State Highway 276 and Freebridge Road, at the west end of County Road 1540 in the City of East Tawakoni in Rains County, Texas 75472.

CITY OF FRIONA has applied for a renewal of TCEQ Permit No. WQ0010089001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 550,000 gallons per day via surface irrigation of 186 acres of non-public access agricultural land. The proposed permit will authorize the disposal of treated domestic wastewater at a daily average flow not to exceed 321,000 gallons per day via surface irrigation of 186 acres of non-public access agricultural land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located 4,000 feet east of the city limits of Friona in a northeasterly direction on U.S. Highway 60 and on the south side of the Atchison, Topeka & Santa Fe (A.T. & S.F.) Railroad in Parmer County, Texas 79035.

CITY OF PETROLIA has applied for a renewal of TCEQ Permit No. WQ0010247001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 75,000 gallons per day via surface irrigation of 12 acres of non-public access pastureland. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located approximately 3,700 feet due east of the intersection of State Highway 148 and Farm-to-Market Road 2332 in Clay County, Texas 76377.

CITY OF HARLINGEN WATERWORKS SYSTEM has applied for a major amendment to TPDES Permit No. WQ0010490003 to authorize an increase in the discharge of treated domestic wastewater from an annual average flow not to exceed 6,200,000 gallons per day to an annual average flow not to exceed 10,000,000 gallons per day and remove Outfall 101 (industrial wastewater outfall) and Outfall 001 (combined municipal-industrial wastewater outfall). The current permit authorizes the permittee to dispose of sludge at a TCEQ authorized 16.31 acres dedicated land disposal site located adjacent to the wastewater treatment facility. The facility is located approximately 0.25 mile south of the intersection of East Harrison Avenue (Farm-to-Market Road 106) and 56th Street, and 2.5 miles east of the intersection of Business Highway 77 and East Harrison Avenue in the City of Harlingen in Cameron County, Texas 78551.

CITY OF QUANAH has applied for a renewal of TPDES Permit No. WQ0010600001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 465,000 gallons per day. The facility is located at 1009 East Nelson Street in the City of Quanah in Hardeman County, Texas 79252.

CITY OF RIO GRANDE CITY has applied for a renewal of TPDES Permit No. WQ0010802001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 1,500,000 gallons per day. The facility is located on the north bank of the Rio Grande, approximately 0.5 mile upstream of the International Bridge (Farm-to-Market Road 755) on the Old Fort Ringgold Site east of Rio Grande City in Starr County, Texas 78582.

SPENCER ROAD PUBLIC UTILITY DISTRICT has applied for a renewal of TPDES Permit No. WQ0011472001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 980,000 gallons per day. The facility is located at 14315 Scotney Castle Street, approximately 2,000 feet west of the intersection of Jackrabbit Road and Spencer Road (Farm-to-Market Road 529), approximately 1.1 miles east of the intersection of State Highway 6 and Spencer Road, approximately 500 feet north of Spencer Road, adjacent to the east bank of Horsepen Creek in Harris County, Texas 77095.

NORTHWEST HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO. 16 has applied for a renewal of TPDES Permit No. WQ0011935001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 990,000 gallons per day. The facility is located at 6303 Bowtrail Street, Houston, approximately 5,800 feet southwest of the intersection of Farm-to-Market Road 529 (Spencer Road) and State Highway 6 in Harris County, Texas 77084.

MONTGOMERY COUNTY MUNICIPAL UTILITY DISTRICT NO. 19 has applied for a renewal of TPDES Permit No. WQ0011970001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 715,000 gallons per day. The facility is located on Volunteer Lane, approximately 800 feet east of Budde Road and approximately 1,300 feet northwest of the intersection of Interstate Highway 45 and Sawdust Road in Montgomery County, Texas 77380.

HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO. 216 has applied for a renewal of TPDES Permit No. WQ0012682001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 400,000 gallons per day. The facility is located adjacent to and south of the feeder road for Interstate Highway 10, approximately 0.6 mile east of Barker Cypress Road and approximately 2.0 miles west of State Highway 6 in Harris County, Texas 77094.

THE CARDON GROUP, L.L.C. has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014989001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 960,000 gallons per day. The facility will be located approximately 4,700-feet due west from a point on Farm-to-Market Road 149 that is approximately 1,620-feet north-northeast of the intersection of Karen Switch Road and Farm-to-Market Road 149 in Montgomery County, Texas 77354.

Concentrated Animal Feeding Operation

The following require the applicants to publish notice in a newspaper. Written comments and requests for a public meeting may be submitted to the Office of the Chief Clerk, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

Consideration of the application by TEXAS HOGS, LLC AND MURPHY-BROWN, LLC for a New Texas Pollutant Discharge Elimination System (TPDES)/State Permit No. WQ0004906000, for a Concentrated Animal Feeding Operation (CAFO), to authorize the applicant to operate an existing swine facility at a maximum capacity of 34,000 head. The facility is located on the north side of State Highway 15, approximately 4 miles west of Follett in Lipscomb County, Texas. The Commission will also consider requests for hearing or reconsideration, related responses and replies, public comment and the Executive Director's response to comments. (Robert Brush, Joseph Ballard).

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, Toll Free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.TCEQ.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201100221
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: January 19, 2011

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## Texas Ethics Commission

List of Late Filers

Listed below are the names of filers from the Texas Ethics Commission who did not file reports, or failed to pay penalty fines for late reports in reference to the listed filing deadline. If you have any questions, you may contact Robbie Douglas at (512) 463-5780.

**Deadline: Personal Financial Statement due April 30, 2010**

Sylvia Barnes, 4853 Post Oak Timber, Houston, Texas 77056

TRD-201100165
David A. Reisman
Executive Director
Texas Ethics Commission
Filed: January 14, 2011

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## Texas Facilities Commission

Request for Proposals #303-1-20267

The Texas Facilities Commission (TFC), on behalf of the Texas Health and Human Services Commission, the Texas Department of Aging and Disability Services, and the Texas Department of Assistive and Rehabilitative Services, announces the issuance of Request for Proposals (RFP) #303-1-20267. TFC seeks a five or ten year lease of approximately 6,962 square feet of usable office space in the City of Waxahachie, Ellis County, Texas.

The deadline for questions is February 7, 2011, and the deadline for proposals is February 14, 2011, at 3:00 p.m. The target award date is March 16, 2011. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TFC Contract Specialist Sandy Williams at (512) 475-0453 or sandy.williams@tfc.state.tx.us. The RFP and any addendum to the original RFP will be posted to the Electronic State Business Daily. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=92753.*

TRD-201100207
Kay Molina
General Counsel
Texas Facilities Commission
Filed: January 19, 2011

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Request for Proposals #303-1-20269

The Texas Facilities Commission (TFC), on behalf of the Comptroller of Public Accounts, announces the issuance of Request for Proposals (RFP) #303-1-20269. TFC seeks a five year lease of approximately 1,901 square feet of usable office space in the City of San Antonio, Bexar County, Texas. Space shall be located within an area bound as follows: Begin at Highway 90 and Highway 353, proceed Southwest on Highway 353 to Zarzamora Street, proceed South on Zarzamora Street to SW Military Drive, proceed East on SW Military Drive to Highway 281, proceed North on Highway 281 to Highway 90.

The deadline for questions is February 7, 2011, and the deadline for proposals is February 14, 2011, at 3:00 p.m. The target award date is April 1, 2011. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TFC Contract Specialist Sandy Williams at (512) 475-0453 or sandy.williams@tfc.state.tx.us. The RFP and any addendum to the original RFP will be posted to the Electronic State Business Daily. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=92754.*

TRD-201100208
Kay Molina
General Counsel
Texas Facilities Commission
Filed: January 19, 2011

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## Texas Funeral Service Commission

Correction of Error

The Texas Funeral Service Commission proposed amendments to 22 TAC §203.33, concerning Consequences of a Criminal Conviction, in the January 7, 2011, issue of the *Texas Register* (36 TexReg 14). Subparagraph (K) was omitted in error from subsection (i)(1) (formerly

subsection (h)(1)) of the rule text on page 15. The corrected text of the rule reads as follows:

(J) tampering with a governmental record;

(K) forgery;

(L) perjury;....

TRD-201100213

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## Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission (HHSC) intends to submit to the Centers for Medicare and Medicaid Services (CMS) a request for an amendment to the Home and Community-based Services (HCS) waiver program, under the authority of §1915(c) of the Social Security Act. The HCS waiver program is currently approved for the five-year period beginning September 1, 2008, and ending August 31, 2013. The proposed effective date for the amendment is September 1, 2010.

The HCS waiver program provides services and supports to persons with intellectual disabilities who live in their own home or family home, or in a community setting such as a small group home. To be eligible for the program, individuals must meet financial eligibility criteria as well as level of care criteria for admission to an intermediate care facility for individuals with mental retardation.

This amendment is to implement a rate enhancement program. The rate enhancement program is an optional program that offers additional funds to providers to pass on to their attendant staff through salaries, wages, benefits, and mileage. Providers who choose to participate in the rate enhancement program are required to meet certain spending requirements and are required to submit documentation verifying they have met these requirements. This amendment is required by the HHSC Budget Rider 67 of the 2010-2011 General Appropriations Act (Article II, Senate Bill 1, 81st Legislature, Regular Session, 2009).

CMS requires the state to monitor each Medicaid waiver program for quality. To ensure the state meets CMS requirements in this area, the state has developed performance requirements that will be monitored at least annually. This amendment includes revisions to these requirements.

HHSC is requesting that the waiver amendment be approved for the period beginning September 1, 2010, through August 31, 2013. This amendment maintains cost neutrality for waiver years 2010 through 2013.

To obtain copies of the proposed waiver amendment, interested parties may contact Christine Longoria by mail at Texas Health and Human Services Commission, P.O. Box 85200, Mail Code H-370, Austin, Texas 78708-5200, telephone (512) 491-1152, fax (512) 491-1957, or by email at Christine.Longoria@hhsc.state.tx.us.

TRD-201100178

Steve Aragon

Chief Counsel

Texas Health and Human Services Commission

Filed: January 18, 2011

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## Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout TX" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

| Location | Name | License # | City | Amend-ment # | Date of Action |
|---|---|---|---|---|---|
| Arlington | Heartplace, P.A. | L06336 | Arlington | 00 | 01/10/11 |
| Midland | Allied Wireline Services, L.L.C. | L06374 | Midland | 00 | 01/04/11 |
| San Antonio | South Texas Oncology and Hematology, P.A. dba Start Center for Cancer Care | L06300 | San Antonio | 00 | 01/05/11 |
| San Antonio | Northeast Cardiovascular, L.L.C. | L06364 | San Antonio | 00 | 01/14/11 |
| The Woodlands | St. Luke's Community Health Services dba St.Luke's The Woodlands Hospital | L06370 | The Woodlands | 00 | 12/20/10 |

AMENDMENTS TO EXISTING LICENSES ISSUED:

| Location | Name | License # | City | Amend-ment # | Date of Action |
|---|---|---|---|---|---|
| Abilene | Lowther Consulting, Inc. | L06042 | Abilene | 04 | 01/13/11 |
| Alvin | Team Industrial Services, Inc. | L00087 | Alvin | 221 | 01/04/11 |
| Amarillo | The Don and Sybil Harrington Cancer Center | L03053 | Amarillo | 49 | 01/12/11 |
| Arlington | Dallas Cardiology Associates, P.A. dba Heart Place of Arlington | L05855 | Arlington | 07 | 01/10/11 |
| Austin | Valley Eye Center, P.A. | L02639 | Austin | 13 | 01/03/11 |
| Austin | Valley Eye Center, P.A. | L02639 | Austin | 14 | 01/10/11 |
| Austin | Hospira, Inc. | L03340 | Austin | 18 | 01/11/11 |
| Baytown | Jacinto Medical Corporation dba Jacinto MRI and Diagnostic Center | L04808 | Baytown | 17 | 01/13/11 |
| Brownsville | Columbia Valley Healthcare System, L.P. dba Valley Regional Medical Center | L02274 | Brownsville | 45 | 01/10/11 |
| College Station | Texas A&M University | L05683 | College Station | 14 | 01/10/11 |
| Conroe | Drilling Specialties Company | L04825 | Conroe | 14 | 01/05/11 |
| Corpus Christi | Radiology Associates, L.L.P. | L04169 | Corpus Christi | 53 | 01/12/11 |
| Dallas | Baylor Radiosurgery Center dba Baylor University Medical Center | L05842 | Dallas | 17 | 01/07/11 |
| Desoto | Vishu Lammata, M.D., P.A. | L05311 | Desoto | 12 | 12/31/10 |
| Desoto | Heartmasters, P.A. | L05760 | Desoto | 06 | 01/14/11 |
| Edinburg | Doctors Hospital at Renaissance, Ltd. dba Doctors Hospital at Renaissance | L05761 | Edinburg | 28 | 01/12/11 |
| El Paso | Blood Systems, Inc. dba United Blood Services | L05841 | El Paso | 08 | 01/11/11 |
| El Paso | Cancer Radiation Specialty Clinics of El Paso | L06095 | El Paso | 06 | 01/12/11 |
| Houston | The Methodist Hospital | L00457 | Houston | 178 | 01/11/11 |
| Houston | Memorial Hermann Hospital System dba Memorial Hospital Memorial City | L01168 | Houston | 123 | 01/03/11 |
| Houston | The University of Texas Health Science Center at Houston | L02774 | Houston | 59 | 01/03/11 |
| Houston | Texas Southern University | L03121 | Houston | 29 | 12/31/10 |
| Houston | M. Basith Baig, M.D., P.A. | L05666 | Houston | 06 | 01/14/11 |
| Irving | Las Colinas Oncology, MSO, L.P. dba Las Colinas Cancer Center | L06078 | Irving | 07 | 12/30/10 |
| Kingwood | E. John R. Samuel, M.D., P.A. | L05232 | Kingwood | 04 | 01/03/11 |
| La Porte | E. I. Dupont De Nemours & Company | L00314 | La Porte | 87 | 01/12/11 |
| Laredo | Laredo Texas Hospital Company, L.P. dba Laredo Medical Center | L01306 | Laredo | 70 | 01/05/11 |
| Midland | Capitan Corporation | L05824 | Midland | 06 | 01/05/11 |
| Paris | Advanced Heart Care, P.A. | L05290 | Paris | 30 | 01/03/11 |

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED):

| Location | Name | License # | City | Amend-ment # | Date of Action |
|---|---|---|---|---|---|
| Plano | Comprehensive Breast Care Center of Texas, Inc. dba Solis Womens Health | L05601 | Plano | 13 | 01/03/11 |
| Plano | Doctors of Internal Medicine | L06086 | Plano | 02 | 01/11/11 |
| Port Lavaca | Union Carbide Corporation | L00051 | Port Lavaca | 95 | 01/13/11 |
| San Antonio | Methodist Healthcare System of San Antonio Ltd., L.L.P. | L00594 | San Antonio | 281 | 01/07/11 |
| San Antonio | Methodist Healthcare System of San Antonio Ltd., L.L.P. | L00594 | San Antonio | 282 | 01/13/11 |
| San Antonio | Cardinal Health | L02033 | San Antonio | 104 | 01/14/11 |
| San Antonio | San Antonio Endovascular and Heart Institute | L05766 | San Antonio | 07 | 01/14/11 |
| Throughout TX | Fugro Consultants, Inc. | L03875 | Austin | 24 | 01/07/11 |
| Throughout TX | Fargo Consultants, Inc. | L05300 | Dallas | 12 | 01/06/11 |
| Throughout TX | Frontera Materials, Inc. | L04830 | Elsa | 17 | 01/05/11 |
| Throughout TX | City of Fort Worth | L01928 | Fort Worth | 23 | 01/04/11 |
| Throughout TX | Varco, L.P. | L00287 | Houston | 129 | 01/05/11 |
| Throughout TX | Williams Brothers Construction Company, Inc. | L04823 | Houston | 08 | 01/06/11 |
| Throughout TX | Acuren Inspection, Inc. | L01774 | La Porte | 266 | 01/12/11 |
| Throughout TX | Qisi, Inc. dba Quality Inspection Services | L06219 | La Porte | 06 | 01/13/11 |
| Throughout TX | Eagle X-Ray, Inc. | L03246 | Mont Belvieu | 102 | 01/10/11 |
| Throughout TX | Techcorr USA, L.L.C. dba Aut Specialists, L.L.C. | L05972 | Palestine | 81 | 01/06/11 |
| Throughout TX | Quantum Technical Services, Inc. | L03731 | Pasadena | 35 | 01/11/11 |
| Throughout TX | Schlumberger Technology Corporation | L00109 | Sugar Land | 59 | 01/12/11 |
| Throughout TX | Schlumberger Technology Corporation | L01833 | Sugar Land | 163 | 01/13/11 |
| Throughout TX | Blazer Inspection, Inc. | L04619 | Texas City | 62 | 01/10/11 |
| Throughout TX | SWL Group, Inc. dba Southwest Laboratories, Inc. | L05269 | Texas City | 16 | 01/04/11 |
| Throughout TX | Langerman Foster Engineering Co., L.L.C. | L06382 | Waco | 01 | 01/05/11 |

RENEWAL OF LICENSES ISSUED:

| Location | Name | License # | City | Amend-ment # | Date of Action |
|---|---|---|---|---|---|
| Throughout TX | Professional Services Industries, Inc. | L02476 | El Paso | 24 | 12/30/10 |
| Throughout TX | Wilson Inspection X-Ray Services, Inc. | L04469 | Corpus Christi | 68 | 12/29/10 |
| Throughout TX | Wren Oilfield Services, Inc. | L04690 | White Oak | 10 | 01/11/11 |
| Throughout TX | Mactec Engineering and Consulting, Inc. | L05490 | Addison | 15 | 01/06/11 |

TERMINATIONS OF LICENSES ISSUED:

| Location | Name | License # | City | Amend-ment # | Date of Action |
|---|---|---|---|---|---|
| San Antonio | Heart Hospital of San Antonio, L.P. dba Texsan Heart Hospital | L05722 | San Antonio | 17 | 01/07/11 |
| Sulphur Springs | Medical Surgical Clinic of Sulphur Springs dba Sulphur Springs Family Health Care Associates | L05701 | Sulphur Springs | 19 | 01/03/11 |
| Throughout TX | Conam Inspection and Engineering, Inc. | L05010 | Pasadena | 185 | 01/05/11 |
| Throughout TX | Warrington, Inc. | L03074 | Pflugerville | 29 | 01/05/11 |

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of 25 Texas Administrative Code (TAC) Chapter 289 regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - Mail Code 2835, P.O. Box 149347, Austin, TX 78714-9347. For information call (512) 834-6688.

TRD-201100189
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: January 18, 2011

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## Texas Department of Housing and Community Affairs

### Notice of Public Hearing

Multifamily Housing Revenue Bonds (Chatham Green Apartments) Series 2011

Notice is hereby given of a public hearing to be held by the Texas Department of Housing and Community Affairs (the Issuer) at Foster Elementary School, 1025 High Point, Arlington, Texas 76015, at 6:00 p.m. on February 15, 2011, with respect to an issue of tax-exempt multifamily residential rental development revenue bonds in an aggregate principal amount not to exceed $10,000,000 and taxable bonds, if necessary, in an amount to be determined, to be issued in one or more series (the Bonds), by the Issuer. The proceeds of the Bonds will be loaned to Chatham Renovation, L.L.C., a Missouri limited liability company, or a related person or affiliate thereof (the Borrower) to finance a portion of the costs of acquiring, rehabilitating and equipping a multifamily housing development (the Development) described as follows: an approximately 234-unit multifamily housing development to be located at approximately 3532 Chatham Green Lane, Arlington, Texas. Upon the issuance of the Bonds, the Development will be owned by the Borrower.

All interested parties are invited to attend such public hearing to express their views with respect to the Development and the issuance of the Bonds. Questions or requests for additional information may be directed to Teresa Morales at the Texas Department of Housing and Community Affairs, P.O. Box 13941 Austin, TX 78711-3941; (512) 475-3344; and/or teresa.morales@tdhca.state.tx.us. For more information go to http://www.tdhca.state.tx.us/hf.htm.

Persons who intend to appear at the hearing and express their views are invited to contact Teresa Morales in writing in advance of the hearing. Any interested persons unable to attend the hearing may submit their views in writing to Teresa Morales prior to the date scheduled for the hearing. Individuals who require a language interpreter for the hearing should contact Teresa Morales at least three days prior to the hearing date. Personas que hablan español y requieren un intérprete, favor de llamar a Jorge Reyes al siguiente número (512) 475-4577 por lo menos tres días antes de la junta para hacer los preparativos apropiados.

Individuals who require auxiliary aids in order to attend this meeting should contact Gina Esteves, ADA Responsible Employee, at (512) 475-3943 or Relay Texas at (800) 735-2989 at least two days before the meeting so that appropriate arrangements can be made.

TRD-201100175
Michael Gerber
Executive Director
Texas Department of Housing and Community Affairs
Filed: January 18, 2011

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## Texas Department of Insurance

### Notice of a Public Hearing on Proposed Revisions to 28 TAC Chapter 3

The Texas Department of Insurance (Department) will conduct a public hearing to receive testimony regarding proposed revisions to 28 TAC Chapter 3, Subchapter X, regarding proposed amendments to §§3.3701 - 3.3706 and new §§3.3707 - 3.3713, concerning preferred provider benefit plans and network adequacy requirements, under the requirements of Texas Government Code Chapter 2001, Subchapter B.

The Department will hold a public hearing on this proposal under Docket No. 2726 beginning at 9:30 a.m. on February 8, 2011, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe St. in Austin, Texas 78701. Written and oral comments presented at the hearing will be considered. A copy of the rule proposal filed with the *Texas Register* for publication in the January 28, 2011 issue can be found at http://www.tdi.state.tx.us/rules/2011/parules.html.

For information regarding the proposed amendments you may contact LHLMgmt@tdi.state.tx.us.

TRD-201100162
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: January 14, 2011

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## Texas Department of Insurance, Division of Workers' Compensation

### Correction of Error

The Texas Department of Insurance, Division of Workers' Compensation (division) adopted amendments to 28 TAC §§180.1 - 180.3, 180.8, 180.22, 180.24, 180.25, 180.27 and 180.28 in the December 31, 2010,

issue of the *Texas Register* (35 TexReg 11873). Due to an error in the division's document submission, the definition for "rules" was omitted from §180.1, relating to Definitions. The inclusion of paragraph (22) concerning rules necessitates the renumbering of the subsequent definitions.

The rule text at the top of page 11892, left column, should read as follows:

(21) Remuneration--Any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, including, but not limited to, forgiveness of debt.

(22) Rules--The division's rules adopted under Labor Code, Title 5.

(23) Sanction--A penalty or other punitive action or remedy imposed by the commissioner on an insurance carrier, representative, injured employee, employer, or health care provider, or any other person regulated by the division under the Act, for an administrative violation.

(24) SOAH--The State Office of Administrative Hearings.

(25) System Participant--A person or their agent subject to the Act or a rule, order, or decision of the commissioner.

TRD-201100218

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## Public Utility Commission of Texas

### Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on January 13, 2011, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Texas Mid-Gulf Cablevision, LP to Amend its State-Issued Certificate of Franchise Authority, Project Number 39071.

The requested amendment is to expand the service area footprint to include all unincorporated areas of Wharton County and all unincorporated areas of Brazoria County, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 39071.

TRD-201100168
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 14, 2011

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### Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on January 13, 2011, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Mid-Coast Cablevision, LP to Amend its State-Issued Certificate of Franchise Authority, Project Number 39072.

The requested amendment is to expand the service area footprint to include all unincorporated areas of Wharton County and all unincorporated areas of Jackson County, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 39072.

TRD-201100169
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 14, 2011

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### Notice of Application for Designation as an Eligible Telecommunications Carrier and Eligible Telecommunications Provider

Notice is given to the public of an application filed with the Public Utility Commission of Texas on January 12, 2011, for designation as an eligible telecommunications provider (ETP) and eligible telecommunications carrier (ETC) pursuant to P.U.C. Substantive Rule §26.417 and §26.418, respectively.

Docket Title and Number: Application of A Plus Telecom, Inc. for Designation as an Eligible Telecommunications Carrier (ETC) and Eligible Telecommunications Provider (ETP). Docket Number 39062.

The Application: The company requests ETC/ETP designation to be eligible for federal and state universal service funds to assist it in providing universal service in Texas. Pursuant to P.U.C. Substantive Rule §26.418 and P.U.C. Substantive Rule §26.417, the commission designates qualifying common carriers as ETCs and ETPs for service areas designated by the commission. The company seeks ETC/ETP designation in the entire service area of AT&T Texas as listed in Attachment C to the application. The company holds Service Provider Certificate of Operating Authority Number 60788.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at (888) 782-8477. The deadline for intervention in this proceeding is February 11, 2011. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) (800) 735-2989. All comments should reference Docket Number 39062.

TRD-201100167
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 14, 2011

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### Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 6, 2011, for retail elec-

tric provider certification, pursuant to Public Utility Regulatory Act §39.352.

Docket Title and Number: Application of BlueStar Services, Inc. Pursuant to Substantive Rule §25.107, Docket Number 39045.

Applicant's requested service area is to include the geographic area of the Electric Reliability Council of Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) 1-800-735-2989. All inquiries should reference Docket Number 39045.

TRD-201100177
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 18, 2011

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### Notice of Application to Relinquish a Service Provider Certificate of Operating Authority

On January 11, 2011, CP Telco filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) Number 60723. Applicant intends to relinquish the certificate.

The Application: Application of CP Telco to Relinquish its Service Provider Certificate of Operating Authority, Docket Number 39057.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 4, 2011. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 39057.

TRD-201100166
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 14, 2011

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## Texas Water Development Board

### Applications for January 2011

Pursuant to Texas Water Code §6.195, the Texas Water Development Board provides notice of the following applications:

1. Project ID #72229, the City of Houston, P.O. Box 1562, Houston, Texas 77251-1562, received August 3, 2010, for a five month extension to close a $58,245,000 loan commitment from the Clean Water State Revolving Fund Program.

2. Project ID #21655, Stephens Regional Special Utility District, 206 FM 3099, Breckenridge, Texas 76424, received November 12, 2010, for financial assistance in the amount of $5,800,000 consisting of a $1,740,000 loan and $4,060,000 loan forgiveness from the Drinking Water State Revolving Fund - Disadvantaged Community Program to finance water system improvements utilizing the pre-design commitment option.

3. Project ID #10416, the City of Eden, P.O. Box 15, Eden, Texas 76837, received September 30, 2010, for: (a) a grant in the amount of $2,680,000 from the Economically Distressed Areas Program for state water plan projects; (b) a grant in the amount of $995,000 from the Economically Distressed Areas Program for rural state water plan projects; and (c) a zero percent interest loan in the amount of $1,000,000 from the Water Infrastructure Fund - Rural Program to finance construction of a water supply project, utilizing the pre-design funding option.

4. Project ID #21648, the Upper Trinity Regional Water District, P.O. Drawer 305, Lewisville, Texas 75067, received December 13, 2010, for an eight month extension for the $26,680,000 loan commitment from the Texas Water Development Fund to finance water system improvements, utilizing the pre-design funding option.

5. Project ID #10418, the Beaver Creek Water Control and Improvement District No. 1, 3880 Beaver Creek Drive, Caldwell, Texas 77836, received May 20, 2010, for a grant in the amount of $57,750 from the Economically Distressed Areas Program Research and Planning Fund for the preparation of a water facility plan.

TRD-201100134
Kenneth Petersen
General Counsel
Texas Water Development Board
Filed: January 13, 2011

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## How to Use the Texas Register

**Information Available**: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

**Governor** - Appointments, executive orders, and proclamations.

**Attorney General** - summaries of requests for opinions, opinions, and open records decisions.

**Secretary of State** - opinions based on the election laws.

**Texas Ethics Commission** - summaries of requests for opinions and opinions.

**Emergency Rules**- sections adopted by state agencies on an emergency basis.

**Proposed Rules** - sections proposed for adoption.

**Withdrawn Rules** - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

**Adopted Rules** - sections adopted following public comment period.

**Texas Department of Insurance Exempt Filings** - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

**Texas Department of Banking** - opinions and exempt rules filed by the Texas Department of Banking.

**Tables and Graphics** - graphic material from the proposed, emergency and adopted sections.

**Transferred Rules**- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

**In Addition** - miscellaneous information required to be published by statute or provided as a public service.

**Review of Agency Rules** - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

**How to Cite**: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 36 (2011) is cited as follows: 36 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "36 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 36 TexReg 3."

**How to Research**: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online at: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the internet. For website information, call the Texas Register at (512) 463-5561.

## Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

**How to Cite**: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

**How to update**: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Index of Rules***. The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with the ***Texas Register*** page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

**TITLE 1. ADMINISTRATION**
***Part 4. Office of the Secretary of State***
**Chapter 91. Texas Register**
40 TAC §3.704.....950 *(P)*